G O V E R N O R ' S

H1N1 P A N D E M I C I N F L U E N Z A

S U M M I T

Held at the Maner Conference Center
in
Topeka, Kansas
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List of Speakers:
Mr. Roderick Bremby, Secretary of Health & Environment
Ms. Kathleen Sebelius, Secretary of the Department of Health & Human Services
Mr. Mark Parkinson, Governor, State of Kansas
Dr. Jason Eberhart-Phillips, State of Kansas Health Director
Mr. Tod Bunting, Kansas Adjutant General
Ms. Alexa Posney, Kansas Commissioner of Education
Colonel Terry Maple, Superintendent of the Kansas Highway Patrol
Ms. Claudia Blackburn, Director, Sedgwick County Health Department
Mr. Michael Mathes, Superintendent, U.S.D. 345
Ms. Torri Behnke-Spiegelhalter, AT&T Homeland Security Division
Doctor Dennis Cooley, Pediatrician

GOVERNOR PARKINSON: I-- I want to welcome all of you today - those of you that are here in the room and those of you that are watching this by broadcast across the state - to the H1N1 Flu Summit. It's very important to us that you're here today, that you're participating, and we appreciate it very much.

I want to, first of all, start out by thanking the folks that are most responsible for this. And at the top of that list is Secretary Bremby and his staff at KDHE, which has done a terrific job, from the very first day that I heard about H1N1, in keeping us informed of exactly what was happening initially in Mexico and then very quickly in Kansas - and now, unfortunately, across the world - in advising us exactly what has been going on and providing us with some very reasoned and rational advice as we've gone throughout the entire process.

I think we should, first of all, recognize Secretary Bremby and KDH&E. Thank you. (Applause). And I'd also like to recognize General Tod Bunting, who's our Adjutant General in charge of our emergency

preparedness and will be in charge of helping us execute what will be a very complicated plan as we addressed both the distribution of vaccines, as well as the administration of those vaccines and, in addition, the distribution and administrations of dosages. General Bunting has been very helpful to our office, again, all along the way.

Our cabinet team just two weeks ago participated in a exercise where we assumed a worst-case scenario and went through a variety of scenarios as what we would do in such a situation. So I'd like to recognize General Bunting and his team for all that they have done. (Applause).

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SECRETARY SEBELIUS: Thank you, Governor, for letting me join the Kansas summit today. And I, first of all, just want to thank you for following up on what we're trying to have happen around the country, which is doing just what Kansas is doing, pulling together not only key partners in government from the state and county and local level emergency planners, health planners, education partners, but also

folks from the health community and the private sector, because we think this is a-- an all-hands-on-deck moment.

I started this morning in D.C. at the first day of school doing an event with the D.C. school chancellor and the Secretary of Education, driving the message about keeping kids safe in school. I'm now in Atlanta with the-- Doctor Frieden and the Centers for Disease Control, talking about some of the monitoring and surveillance going on and our new guidance. So this is a-- an appropriate day to be talking to all of you.

Just wanted to make a couple of points at the outset. That we know that the illness has been mild to date. But, you know, in Kansas, you've seen a number of people hospitalized and a death already. We know that the summer flu activity has been unusually high in Kansas. And what we are seeing in the southern hemisphere leads us to believe that an escalation of-- of cases will occur across this country in the coming months.

Without a successful vaccination program, the modeling indicates that as many as 20 to 40

percent of-- of the Kansas population, between 550,000 and 1.1 million Kansans could be affected in the next two years. And many of those cases are likely to come in waves of infection lasting several weeks. So what we know is that we could have a healthcare system that is stressed and may be overwhelmed at the peaks of the pandemic.

Our vaccine advisory group has identified five priority populations in-- to get the message out to who seem to be particularly likely to be infected by this new virus. Pregnant women who represent 1 percent of the population but have represented 6 percent of the hospitalizations and deaths so far, caregivers of children younger than six months, because we know that babies aren't recommended for vaccine and their parents and guardians and caregivers should be at the front of the line. All Kansas children six months up until 24 years old. So kids on college campuses, K through 12, kids in daycare centers. And that's primarily because this is a-- where the virus has gone, they're the best transmitters of the virus. Certainly healthcare personnel

come to the front of the line. And anyone 25 to 64 years old with an underlying health condition.

With schools open in Kansas and opening across the country, we have some work to do before we have a vaccine available. What we know is that the average age of the confirmed cases in Kansas is 17. And 80 percent of the Kansas cases are in folks under 35 years old. So it-- this is clearly a young flu.

I know from my personal experience in the state and certainly my six years as Governor of the Great State of Kansas how good our emergency responders are and how good our efforts to work together are. I put it up against any country-- I mean, any state across the country. But this is going to be a-- very much a partnership effort. And we at the federal level are committed to not only helping to get resources to states across the country, but also to get good information to you on a regular basis.

The public health and healthcare systems are mobilizing efforts to make sure that the vaccine - once it is proven to be safe and

effective - is available to all Kansans. We're-- already have plans with KDHE coordinating with local health departments to plan a statewide vaccination campaign involving a wide range of partners; private healthcare providers, primary care clinics, retail pharmacies, as well as new partners, schools and other mass vaccination sites that you'll be talking about later today.

We still think we're on target for the first of the vaccine to become available by the middle of October. And our numbers will be updated as we get a little closer. We're working with five different manufacturers, so it's-- it's difficult right now to give very precise numbers, but we will make sure and feed those out as we know them.

In the short-term, though, I would say certainly between now and mid-October, we know that it's important to get the message out about not only good personal hygiene with hand-washing becoming a part of daily routines at schools and anyplace children are gathered, alcohol-based hand sanitizers, but also getting employers and parents to come up with backup

plans for how to keep employees and how to keep children home when they're sick.

It often requires thinking of an alternative caregiver, thinking of a way that-- to keep a continuity of business going with sick employees staying home. It's going to be particularly important in the areas where workers may feel jeopardized if they don't show up for work. So hourly workers. It's not going to do an employer much good if a worker comes to work feeling that he or she will lose their job, only to get the rest of the work force sick.

So it's a-- a situation where we're very much urging employers to re-examine sick leave policies and flexible policies, and hopefully don't make people get notes from doctors, because that could overwhelm the healthcare system. And we need to find ways to encourage folks who have the flu just to stay home and take care of the flu. Everyone doesn't need to see a doctor. Certainly everyone should not show up at a hospital. So ways to take the pressure off our healthcare system so that they can deal not with the worried well, but with

the truly sick.

So this is going to be a-- a multi-step effort involving lots of partnerships. flu.gov is up and running as a website. CDC will be continually updating guidance and information. We will continue to get information out to the states. But I just so much appreciate the Kansas leadership for being out ahead of this, gathering people together to have a dialogue about how we can make sure kids continue to learn, workplaces continue to operate, and we keep all our citizens as safe and secure as possible.

So thank you, Governor, for letting me join you. Thanks for putting on this program today. And I look forward to giving you regular updates as we move closer to a vaccination system this fall.

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GOVERNOR PARKINSON: Let me just make three very brief points and then we'll turn it over to the true experts. The-- the first point that I want to make that-- that your presence suggests you're already completely aware of is that this has the potential to be a

very serious health problem. What we know about H1N1 is that it is immune from the current vaccines. We also know that it can be administered-- or it can be transmitted from a person to other people, and we know that this can take place pretty actively. And so as Secretary Sebelius pointed out, there have already been thousands of cases of H1N1 in Kansas alone and, of course, many more across the country and across the world.

What we also know from history is that it is possible for the severity of a flu virus to mutate. The good news so far has been that H1N1 - although deadly in limited cases - has proven to be no more deadly than what people would consider to be the common flu. Unfortunately, we can't rest on that knowledge, though, because of the possiblity of H1N1 mutating into something much more serious. And we know that this has happened historically, and we know that when it has happened, it has been met with very-- we have been met with very negative consequences around the world.

In fact, for the last three centuries around the world, there have been three great

flu pandemics in each of those centuries. If you just go back to the 20th Century, if you look at the 1900s, the three great pandemics started with the Spanish flu in 1918 where an astonishing 50 million people across the world died of the Spanish flu. And one thing that it has in common-- or had in common with H1N1 is that 99 percent of those fatalities were among people that were under the age of 65, 50 percent were among people ages 20 to 40. So we certainly know from our experience with the Spanish flu that the possibility of the flu killing tens of millions of people is possible across the globe.

That was then followed up with the Asian flu and the Hong Kong flu in both the 1950s and the 1960s where in the vicinity of 1 to 2 million people died worldwide in each of those pandemics. So H1N1 is nowhere near that level of severity at this point, but we know that at any time it could mutate. And if, in fact, it would mutate into something more serious, given the fact that we currently have no vaccine, the potential threat to people's lives is quite serious.

The second point that I want to make is that for that reason, it's extremely important that although we hope for the best, we prepare for the worst. And although we hope that H1N1 does not mutate into-- to a virus that's any more potent than its current level, we have to prepare and assume that it will. And so for that reason, I'm very appreciative, as I'm sure we all are, that the federal government under Secretary Sebelius' leadership is actively pursuing a vaccine, which I understand that she and others are confident will be a successful vaccine.

And it's important that we figure out a plan to implement it, to get the dosages out, to make sure that they are administered properly. Because when you consider the magnitude of the effort of literally distributing tens of millions of doses across the country, and in Kansas alone potentially distributing up to a million dosages of the vaccine, that is a major undertaking that requires significant preparation. And it's, again, a reason that I'm very pleased that you're here.

And the third point that I want to make is that this is going to require an unprecedented level of cooperation. Cooperation among our local units of government, our state units of government, and the federal government. Among schools, among police officers, public safety officers, among healthcare providers, among a whole array of people. We're all going to have to come together to properly address this. And that is really what the purpose of this summit is, is to bring the folks in this state who will be most responsible for helping prevent and then take care of this problem, together at the same time, so that we can continue the dialogue to make sure that whatever the impact of H1N1 ends up being, that we minimize to the greatest extent possible the impact that it has in Kansas.

So, again, thank you very much for your participation. We could sit back and hope that nothing happens and hope that this virus doesn't get any worse and hope that it's just the normal flu, or we could take affirmative steps to make sure that we do everything we can

to reduce its impact. You being here today proves to me that you've chosen to join our team, which has chosen to take the course of doing everything possible to protect the lives of Kansans. And for that, we appreciate your efforts very much.

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DOCTOR EBERHART-PHILLIPS: Thank you very much. It's-- it's such a privilege to be the state health officer in a state with the leadership that we have in you, Governor Parkinson, in the ability that you've had to absorb an enormous amount of new information and to recognize what the risks are and to be so decisive in-- in your actions. So thank you very much for that.

I have been telling people that the last 41 years of my life have just been fantastic, but they all kind of have come to an end now in terms of the-- the interpandemic period as virologists call it, having come to a close with the declaration in June of this year that the world was now in a pandemic situation.

The WHO has these pandemic alert levels. On that date we raised it to Level 6, the

highest level. Meaning that, in fact, a global epidemic of a new disease agent was underway. And that was based on the fact that community-level outbreaks were occurring not just in one continent or multiple countries in one continent, but in multiple parts of the world simultaneously.

Now, this declaration of a pandemic is a reflection of the global spread of the virus. And it isn't really about the severity of the diseases that it causes. As Governor Parkinson said, this hasn't been a flu - fortunately - that has produced high levels of mor-- mortality, although it has caused considerable morbidity, sickness. This flu is bad news for us because it infects so many people. And so many of us will-- will need to take time out from our normal lives in the-- in the coming months if the predictions are true. And that will impact us in terms of the-- the-- the way we're used to doing business.

The H1N1 flu-- and just really, it's only about 130, 140 days old. But in that time, it has now been confirmed in 177 countries in every continent. Just looking at the map,

there aren't many places left except in certain African countries that-- which probably just haven't been able to find it yet, and maybe Greenland and a few outlying islands.

During the-- what's the winter months in the southern hemisphere, there's been considerable activity in Latin America, in Australia and New Zealand, and in southern Africa. Now a lot of that activity is starting to slow down as they move into their spring months, and we're seeing much more activity in the-- the tropical regions of the world where there are very large populations and not a good way to follow exactly what the-- what spread of disease we can expect.

The World Health Organization estimates that 1,800 people have died thus far from this flu. That's probably an underestimate because many of those deaths are in countries where-- where the cause of death is not clearly ascertained. Still, that's a relatively small number when you consider a planet of 6 billion people. But then again, it's about six times the number who have died from the bird flu, the H5N1 flu since 2003. So that very serious

problem we've already exceeded six times in just four months.

This is an entirely new virus. It's made up of genetic bits that come from flu viruses infecting pigs, birds, and humans. And because it has those human characteristics, it's clearly able to transmit easily among humans, particularly young ones. No one except those who have been infected in the whole world is immune against it. And as such, it can become widespread very quickly. And-- and for now, there's no vaccine, including the seasonal flu vaccine that-- that many of us get every year that can protect us against this infection, although a vaccine is coming soon.

Just to give you a brief rundown on the clinical picture. It's like other flu infections for most people, there's an abrupt fever, usually over 100 degrees in most cases. You have respiratory symptoms like cough, sore throat, sneezing, runny noses, body aches, chills, fatigue. You're just kind of wiped out for a couple of days. This one unusually has more diarrhea and vomiting. Not in everyone, but it's more common than we typically see with

seasonal flu.

Almost everyone recovers fully. It's a self-limited illness for-- for most people, just more of a nuisance than anything. But the hospitalization rate that we have seen from this flu, particularly in younger people, is higher than we would expect from seasonal flu. And of course, as of last week, 522 people have actually died from this infection.

As the Governor had said, this picture can change. This relatively benign picture could-- could shift as the virus infects more people and has more opportunities to change its genetic makeup.

How it spreads? Well, fortunately, we know a lot about that now. That it's a lot like the seasonal flu virus. Through respiratory droplets, these-- these invisible droplets that are ejected every time we cough or sneeze or just speak loudly like I am now, little droplets come out of our respiratory tract and they settle in the area immediately around us. So through coughs and sneezes. And also when those droplets get on our hands and we touch objects that another person can then

touch and then introduce it to their nose or mouth.

Fortunately, these droplets don't travel very far. They fall to the earth relatively rapidly. Three feet for most of them, six feet away maximally. The virus can survive on-- on surfaces. It all depends on how much of a glop of virus you-- you leave there and what the conditions are in that place. We know that it can remain infectious at least for a number of hours, potentially surviving for two or three days.

Looking at the spread of the disease in the United States, the first cases were confirmed just in mid-April in California and Texas. And then here we were in Kansas with the first non-border state having two confirmed cases on the 25th of April. Now there are confirmed cases in all 50 states, the District of Columbia, and most of our territories.

The CDC estimates that the cases have easily exceeded a million in the United States so far. As of last week, more than 7,900 people have been hospitalized because of this infection. The activity has slowed down after

a peak in the month of May, but it is clearly picking up again as we speak every week. This is a very unusual picture in the summer months. And now, more than 97 percent of the flu viruses that are studied in laboratories and isolated there are this bug. So it's become the predominant bug. What-- what will happen in the winter flu months, we don't know. But right now, if you've got the flu, chances are very high that it's this.

The unusual thing about this disease is the age pattern. If we just look here at the hospitalized cases who are the best studied and the ones we're most concerned about in terms of the severe disease, we see that the-- the proportion of cases in children and young adults is very high.

Looking here at more than 7,500 hospitalizations through the 21st of August. And just to give you a comparison, there's those purple bars again with the age distribution that you can see there. If this were the seasonal flu, if we were taking 7,500 hospitalized people with seasonal flu, the yellow bars show you how the ages would-- would

be expected to break down. We'd expect 45 percent of those to be in people over 65 years of age. We wouldn't expect many at all in children and young adults. And yet that's where we're seeing the-- the biggest bulk of this disease. Only 6 percent of hospitalized cases in people over 65. Now, some individuals in that age group who become infected can get serious disease, but the burden of disease is clearly on much younger groups and that is very, very different than the flu we're used to.

We expect-- we-- we predict here that we've had already 10,000 cases. And of course, the vast majority of those have been very mild. And the stresses on our healthcare system have generally been manageable to date. We know of 32 hospitalizations and one death. And we have laboratory-confirmed disease now in 51 of our-- of our 105 counties.

The average age, as I think Secretary Sebelius said, is 17, as it is in-- in most of the rest of the country. The highest rates of disease are in our school-age kids, kindergarten through 12th grade. And

approximately 80 percent of all our cases are under 35.

This just shows you the map. I've been filling in these-- these counties week by week. We actually are filling more counties in during the summer months than we did during the height of the media interest in this outbreak earlier on in the spring. And as you can see, all of the counties with the large population centers are colored in as having confirmed disease at this point.

So what can we expect next? Now, we don't have crystal balls, but it's becoming very apparent that this flu will be back in the upcoming flu season. The timing, the spread, the severity of it cannot really be predicted with much exactitude. But we know from what's happened in the southern hemisphere and the fact that it hasn't even disappeared here during the summer that we're in for a-- a probable escalation of cases.

The World Health Organization predicts 2 billion or more infections in-- in pandemic waves over the next two years. And as Secretary Sebelius said, 20 to 40 percent of

the population here in the United States can be-- we can expect to become ill. That's more than potentially a million people in Kansas.

The CDC estimates that deaths from the H1N1 flu will, over the next two years, range from 90,000, which would be a bad seasonal flu year-- or two years, to several hundred thousands. They can't really be more precise. It's that uncertain. And that could put significant stresses on the healthcare system and disrupt the economy.

Just looking at the healthcare impacts, we know that in certain localities, the early wave of the infection in April and May created localized stresses on emergency departments in particular. And if we study what's happened this flu season in the southern hemisphere in Australia and New Zealand, we-- we can get a sense that peak stresses are likely to occur over a period maybe lasting about four weeks. And that that-- that wave of-- of demand on the healthcare system could escalate very rapidly in a matter of just a few days.

But there will be regional variations from place to place. That was the experience

in-- in those countries. What-- what occurred was a relatively normal seasonal flu pattern in some areas, with extreme demands on healthcare in others areas, such that there were localized shortages of intensive care beds, respirators, available staff to care for patients, the need to rely on surge capacity, cancelling elective surgeries and so forth.

What we know is that disadvantaged populations in those countries were hit especially hard. Hospitalization rates among Aboriginal Australians, for example, were five times that of the non-Aboriginal population. And across the board, the-- the greatest demands for healthcare came from the care of children.

Just to give you a picture here from New Zealand where they've measured the-- the consultation rate for patients seeking care from their general practitioners, this is their routine way, similar to what we have in this country for monitoring flu in-- in the country, that the-- the bottom lines in blue and black represent their flu seasons in 2007 and 2008. The big hump in the red line is what happened

in 2009. That's looking across the entire country. Some areas were hit more severely than that, others less.

Just looking at the work force impact. If we look at a four-week pandemic wave in Kansas, we-- we estimate that lost work days could range from between 700,000 to 1.2 million, with some assumptions about the duration of illness, the proportion of workers who have to stay home to take care of ill family members. That's about a rate of 3 to 6 percent of all potential work days during that four-week period.

But those lost work days won't be spread uniformly in time or in place. We can expect that particular communities, particular industries at particular times could have a-- a-- be hit particularly hard. We know from looking again at what happened in Australia and New Zealand and in an interesting summertime outbreak in the United Kingdom in the month of July, that the actual peak absenteeism at the-- at the worst phase of the-- of the pandemic wave was about 10 to 15 percent. And compare that to what happens at the peak of a normal

flu season outbreak, it's about double.

The total economic impact, looking at what people have studied in-- in Argentina and other countries in Latin America is that this overall had cost their economies about 1 percent of their gross domestic product for the 2009 year.

Our objectives at KDHE and in local public health are fairly straightforward. Our goal is to decrease the risk of hospitalization and death. We can't contain it. It's out of the bag, we can't stop the tide. But we can do things to reduce the severity and slow it down. And we can do that in ways that we hope will minimize the social and economic disruption that this threat presents.

We do that through surveillance and forecasting, community mitigation. That's policies like social distancing, excluding ill people from school and work, educating the public. And through the vaccine campaign, coordinating the public's uptake of the new H1N1 vaccine while we simultaneously promote the seasonal flu vaccine.

Just briefly on surveillance. We are now

moving towards a system of aggregate surveillance. Previously we identified each case. As a physician identified someone, they would test them and it would go to our laboratory. We simply haven't got the capacity any longer to have that kind of a passive system.

Instead, we're going to get a broader impression without getting an exact count of the flu activity throughout the state. We're doing that by having emergency departments, safety net clinics, and other providers report to us on a weekly basis what proportion of their patients have influenza-like illness. And then we're going to obtain from those sites two specimens each week which we will test to see what proportion of cases are, in fact, being identified as flu are, in fact, due to this organism. And we'll also continue to test inpatients as long as we can at the Health & Environment laboratory.

This is the kind of reports that-- it's-- it's kind of hard to see all the circles there, but throughout the state we'll get an idea based on the color of the circle just what

proportion of ambulatory patients are coming in with influenza-like illness. The size of the circle being the size of the facility that's reporting.

We also are doing a lot of work around community mitigation. And what that means is first educating the public on how this disease spreads, how to prevent it, how people should stay home for at least 24 hours after their fever resolves before returning to work or school, how to keep distance from other people who appear ill. Educating employers and schools about how to recognize the disease, dismiss workers or-- or students who develop symptoms, reduce face-to-face contact in the work force if it-- in the workplace, rather, if-- if it becomes a-- a concern that the disease has become more serious. And possibly cancelling large gatherings of people where in crowded conditions the virus can spread.

Key public prevention messages are for folks to wash their hands often, as Secretary Sebelius said, especially after they cough or sneeze. Alcohol-based hand sanitizers are okay where soap and water aren't available, although

the soap and water is preferable. Cover your nose and mouth when you cough or sneeze, not with your bare hands but using a tissue and throw that away. If you don't have a tissue, the Dracula cover is a-- is another way to do it, into your sleeve. Again, protecting the people around you. Stay informed and-- because what we know about this virus is really changing every day. And of course, stay home when you are ill.

Commissioner Alexa is going to talk a lot more about what's going on in the schools. We've learned a lot since the massive school closures in the spring that-- that made all the news. In most instances, we believe now that closing schools isn't the best way to control this disease. It's not only ineffective, it disrupts schools and whole communities in unproductive ways. And there's some evidence that students will re-congregate in other settings when we close the school doors.

So our goal is to keep schools open, safe and functioning. Our motto is: Well kids belong in schools, sick children belong at home. And that's the message we're going to

get out to parents throughout Kansas.

Just a few words now about the H1N1 vaccine. As Secretary Sebelius said, five manufacturers are already producing the initial lots of the vaccine. Clinical trials in human volunteers have begun in this country and around the world. We-- we will learn a lot from those trials, but we can anticipate that they're going to suggest, at least for most age groups, that this is a two-dose schedule. And if you think about it, that's 600 million doses potentially just for the United States. Something that would have been inconceivable only two or three years ago. But thanks to preparations for just this day, we can-- we can appreciate this may actually happen as-- as it's planned.

The latest scenario is that in October-- by the middle of October, we will have 45 million doses available around the country, with 80 million doses or about 20 million a week available after that. The share of that total in Kansas, commensurate with our population, is about 1 percent. And what we anticipate is creating a public/private hybrid

kind of system for getting this vaccine out to the population.

The priority groups, as-- as Secretary said, I'll just briefly go through the five target groups identified by the Advisory Committee on Immunization Practices that advises the federal government are pregnant women, household and caregiver contacts of young children under six months of age, healthcare workers involved in direct medical care and emergency medical service personnel, everyone in the population six months through 24 years of age. They are the ones bearing the brunt of this illness. And the people up to age 64 who have chronic medical conditions.

Normally when we're talking about flu vaccine, the focus is on persons over 65. But as you saw, their rate of disease is relatively low, and so they have not been included in the priority groups for the United States. When the demand increased-- is in excess of the availability, as it may be in the beginning, we're going to prioritize the subgroups further. Yes, we'll still have pregnant women and the contacts of those young kids and the

healthcare workers, but now we will focus just on healthy children up through the age of four and we'll wait on the school-age kids until more vaccine comes. And instead of everyone with a chronic medical condition, we will just focus on children with chronic medical conditions. Again, as soon as more vaccine becomes available, 20 million doses a week, we'll rapidly try to open that up.

As the-- as the demand is met locally, we will then go beyond even those initial target populations to give it to healthy adults through age 64. And then it will be extended to healthy adults over the age of 65. Initially the demand will likely exceed the supply, and it's really important that everyone participate in the program understand why we need to get the vaccine to the priority groups first. It will protect all of us if we do it that way.

Nearly half of the people in the priority groups are school-aged children. And that's one reason why we so much want schools to become venues for immunization, in coordination with their local public health departments.

It's a great place to find kids and get them immunized and make sure we can cover virtually everybody.

The seasonal flu vaccine is now available in Kansas. We expect there will be added interest in it this year with all the attention flu is getting. We should have an adequate supply. We'll have the same target groups we've always had. Last year we added everyone through the age of 18. So that continues now. This is the only vaccine, when the H1N1 comes out, that will be for those over 65.

We expect that we'll be able to dose this vaccine simultaneously with the new vaccine. And the question we'll get is, well, what if it wears off? Our-- our-- our advice is that you can get vaccinated now, it will last and carry you through the entire flu season.

So my last slide. We're going to need a whole new mindset. And that's part of why we're here today. We can't stop this new flu. Until there is widespread immunity with a new vaccine, it will continue to spread in our communities, although we can slow it down. So until that day, we have to remain realistic in

what we expect and try to be flexible in our approaches. We have to think in new ways while we get through this. We have to be adaptable for unexpected developments. This is still a very hard thing to predict and nail down exactly what will happen. And we, most importantly, and it's great you-- you are a-- tangible evidence that we are, in Kansas, willing and able to work together.

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MS. BLACKBURN: I am here representing Sedgwick County Health Department, we're a-- one of the larger local health departments in south-central Kansas, in the State of Kansas. I'm also representing the Kansas Association of Local Health Departments, which represents 100 health departments throughout Kansas. Different sizes; some have two full-time staff and some have up to 150, and then in between. And we're all working together to respond to the H1N1 pandemic.

One thing we know in public health is that the public doesn't know the difference between a local health department, the state health department, and what's going on at the

federal level. They expect us all to be on the same page, to have the same message, and to be working together. And so that's why I'm-- I'm really gratified that we are so integrated and we have such a cohesive approach in Kansas.

Keeping our community health is core to what we do in public health. We are responsible for protecting the community from health threats, for promoting health, and assuring that all of our residents have access to essential public health services. But responding to H1N1 and most health issues is not something that a local health department or a state health department or the CDC can do alone. It is something that we have to come together and share responsibility for. And that includes the private sector and every individual really getting informed and being prepared.

And as Doctor Eberhart-Phillips and those that have spoken before me have said, the situation is fluid and evolving. Our plans are written, they're written in pencil. We change them daily as we get new information. And so we just want everybody to understand that what

we tell you today may change tomorrow based on new information.

So I've been asked to talk a little bit about what we're doing at-- on the local end related to H1N1 planning. Well, we have been planning for pan flu since 2005. We thought we'd have a virus, such as bird flu or Avian flu. We thought that the mortality rate from this virus would be very high, that people would be very sick and that we would not have a vaccine. So that's kind of how we built our plan, worst-case scenario.

The good news is that so far, H1N1 has been a generally mild disease, people generally recover. And it looks like we're going to have a vaccine. So that's a really-- that-- that's good news to us in public health.

In 2005, we established the pandemic influenza work group, which consisted of almost 100 people from 25 different agencies; partners from emergency management, emergency medical services, from all the healthcare facilities, the private sector, the schools working together. That group advised our health department on the creation of our pandemic

influenza plan. And we have stayed at-- that group has stayed active, not as active as during the-- the intense planning process, but we reactivated that group in the spring when H1N1 emerged. And they are working with us now to make sure that our response is appropriate. And-- and they are-- are so very helpful in the advice that they give us and the work that they do.

So now we're reviewing our plan, and it is still effective, even though it was written for the worst-case scenario, and we are busy implementing that plan. And the four main steps, and I'm going to go into each one of these, are informing, communication is absolutely key in this process; monitoring the community for disease; carrying out our vaccination plans, and that should be bolded; and then allocating resources. Actually securing and allocating resources.

We have been providing periodic H1N1 updates in the form of a one-page newsletter to our elected officials regularly with interim quick e-mails in between when there's a significant event. And we-- we also share this

information with the pandemic influenza work group. And they, in turn, push that information down to their agencies. We've kept-- we have kept the-- the public informed through press releases, and we do those proactively when there is a significant event, and then we respond to a lot of calls from the media.

We also have a very rich website at Sedgwick County Health Department, and we have Fast Fact sheets and links to other resources and a-- a number of resources for our community. We're doing community presentations and we're getting so much demand now that we're creating a speakers bureau to help us with this.

And then a couple of years ago as part of our pandemic influenza planning, we created a business continuation of operation planning guide that is posted on our website. And it is still very relevant. We pushed 9,000 copies of this out to the community, to the business sector a couple of years ago and we're reviving that and-- and passing those out again. And we'll be doing that at a large business

convention in September.

The health promotion staff has developed a hand-washing campaign in concert with back-to-school, flu season, and National Clean Hands Week in September. It's a really fun campaign. And it consists of a train-the-trainer for people-- people in the schools and then, you know, actually providing the education for large assemblies. And part of the plan is to get this campaign out to the faith-based community, business. Anybody that-- that will have it, we will share it with. Most of the information that we have on our website is in English and Spanish, and we are looking at translating what we have into other languages as well.

Monitoring the community for disease. This is a-- an essential public health service that we provide. We will be relying on the state surveillance system, the influenza-like illness network that Doctor Eberhart-Phillips mentioned. That will be how we track disease in our community.

In addition to that, we have I think eight schools so far that have volunteered to

report their influenza-like illness absenteeism to us on a weekly basis. And that will be really helpful, it will be additional information that will help us know what's going on in the community and be able to target our message more appropriately.

We also have what's called First Watch, it's a-- it's an automated system that gives us data from one of our large hospital emergency departments. We have two large ones. And it-- we get information on influenza-like illness or respiratory syndromes, and we also get information from our emergency management services transport. So those are other ways that we'll be monitoring the disease in the community.

Implementing the vaccine plan. Our goal is to immunize the most people with the least inconvenience to the public and the least disruption to organizations. We intend, as Doctor Eberhart-Phillips explained, to use the existing healthcare system to do this. Work with our providers, work with our hospitals, work with our schools. We will work with whoever is interested in providing this vaccine

onsite.

So right now, we are deeply involved in the planning process and-- and planning to implement. We had an initial meeting with most of the school health coordinators from Sedgwick County, school districts, including private schools and universities. We have three universities that we're working with. And it was primarily information sharing and to get a sense of how many of those sites were interested in having a school-located vaccine clinic.

And really, the support is overwhelming. I can't say it's 100 percent, but there's quite a bit of support for this. And our goal is to provide resources or conduct the clinics, whatever will work for the particular school or university. We will support those clinics with supplies, staff, data entry, whatever is needed. And then we're also coordinating with the universities, as I said, so that we can provide clinics on campus. Some of them have student health centers and they can do some of it. And we'll work with them to-- to make sure that their students have an opportunity to get

vaccinated when the vaccine is available.

And as far as the daycares go, and that's going to be really important if we have to prioritize and immunize the six-month to four-year-old age group first, we are working with the City of Wichita child care licensing agency. They are responsible for daycare licensing in our-- in Sedgwick County. And so we'll be working with them to conduct some large vaccination clinics that are targeted to daycares in our community.

Now, that's different in different communities. A lot of health departments actually do the child care licensing function. And so you might get a-- you might have a different story in your community.

We are meeting with our healthcare facilities tomorrow and we'll be reviewing the CDC guidelines. They have some questions, we understand, about that. We all want to have the same understanding of those guidelines, and we'll seek clarification from KDHE if we need to do that. And we'll discover from them what their plans for vaccinating their healthcare workers are and how we can assist.

And then local providers are pre-registering now. They're expressing their interest electronically to let KDHE know if they want to receive the vaccine. And we will get a list at the local level and then contact the providers who are interested to make sure that they qualify and then work with them to get that vaccine and to sign-- sign whatever agreements need to be signed.

We're also working with large work sites. We do this as part of our regular seasonal flu campaign. We provide mobile clinics to work sites and we'll just follow that model for H1N1. We also have a military base in Sedgwick County. And the military base will re-- receive vaccine for active personnel but not for their family members. And so we'll be visiting with our Air Force Base to find out if they want vaccine to-- from us when we receive it, so that they can vaccinate family members as well. That's just more efficient.

And then we'll be providing vaccine at our health department. And as we move towards vaccinating everybody, the general public, we'll look at opening some of our preplanned

points of dispensing sites to provide to the general public at convenient times, perhaps weekends and evenings.

So right now, we are securing and allocating resources. We anticipate funding coming through the state health department from the CDC for three different phases of implementation. And we are just waiting to get more information on this and finalize contracts, but we are already beginning to plan for, you know, hiring staff to help us with this because it is going to be a lot of work.

We are recruiting volunteers. We have a Medical Reserve Corps in Sedgwick County. We're-- we're recruiting through the Medical Reserve Corps, through our city's readiness initiative, and through outreach to various groups, but-- professional groups, such as the nursing associations, we have a medical school-- we're very fortunate to have a medical school in Sedgwick County, and the Parish Nurse Association. These are just a few examples of the recruitment efforts.

We need lots of volunteers. And we have-- we believe that we'll get lots of

volunteers. When we stood up for Katrina, we had so many volunteers, it was just-- it was really heart-warming. And we expect that we'll have the same, even though this will probably be more of a prolonged request of-- of their time, we do expect to have a good volunteer response. That's just the way Kansans are.

We at the health department are reviewing our own continuation of operation plan. What are our priorities in terms of services, what can we ramp down so that we can pull staff to do this work to help with vaccination clinics. We-- we are preparing our staff for change. We have a weekly newsletter. We're talking about, you know, our mission in public health, what our responsibilities are, what our priorities are, and how important it is that our staff be very flexible and be ready to do something that's not in their day-to-day routine, and how they can plan personally to be ready to respond.

And then we're very fortunate again, we have preventive mental health counseling for our staff to manage stress, because this is stressful. And we have somebody from our

community mental health clinic, which is also part of Sedgwick County, who is visiting with staff proactively to make sure that-- that we're all taking care of ourselves and that we don't let the stress from this enormous response overwhelm us.

So our expected time line. We are going to push seasonal flu vaccine really hard. I appreciate Doctor Eberhart-Phillips' comments on the importance of getting the seasonal flu shot. We expect to get that any time, and we'll start just as soon as we get it, probably early September if all goes well. And then in mid-October, we should have-- we-- we'll be ready to begin vaccinating the priority groups for H1N1, depending on the availability of vaccine and what the guidance is. And then in November hopefully we can move to the general public if there is an adequate vaccine supply.

So our next steps are to do more of what we're doing. Inform, inform, inform. Monitor the community. We know it's here, we know H1N1 in his our community. That's no surprise. We want to know if-- if the levels really increase. We'll continue to prepare for

vaccination and provide regular updates to our elected officials, our partners, and the public.

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GENERAL BUNTING: All right. Good afternoon. I'm pleased to be here to represent Emergency Management and Homeland Security, the entire department. I took notes when the Governor was speaking, as you might imagine, and the-- the Governor left. The thought of another presentation from me was more than he could bear, so the Governor has left. That's actually not true.

I tell you, if I'm going to talk about an overview of Emergency Management and Homeland Security in Kansas, it's best for you to know who's on this team. So I'll start with the professionals that work every day in emergency management, and our state division of emergency management, in our local-- or county emergency managers. So I know they're out there. So if they-- if you're part of that team, would you stand up just so people can see who you are. They're not a shy group. Okay. Those are the folks that work every day with us.

We have a small team in Homeland Security. Primarily Bill Chornyak is here. But also in Homeland Security, something we've added in the last year, so we have Doctor Bob Hull, who works Emergency Management/Homeland Security, works with us in our Safe and Prepared School Commission. So Doctor Hull is here, if you'd stand up. And Bill Chornyak is right here, our deputy here.

All right. And then, of course, the Adjutant General is also responsible for the National Guard. So to make sure that we had a full room here today, I brought along a few or so. So the National Guard folks, stand up so you can see who they are. Okay. And I'll talk about them in particular in a minute when we talk about flexibility.

Okay. A couple other people, because this is-- this is how we do things in Kansas, we are not meeting each other for the first time. All of the training that I have had in five-and-a-half years specific to National Incident Management System and Incident Command System, everything we do each and every day, I've been through all of that training with the

Secretary Bremby and Mindy and Dick from Health & Environment. So you need to know that we're not meeting each other for the first time, we are a team.

In the room today are the Chairman and the Vice-Chairman of the Kansas Commission on Emergency Planning and Response. And that's Jack Taylor and-- and John Prather from Groendyke. So the two of you stand up. I'm calling you out now so people know you're here as well. There you are.

And what's important for you to know about that is; the Chairman and the Vice-Chairman of the Kansas Commission on Emergency Planning and Response is a fire chief and an EMS director and a member of private industry. And we're immensely proud of that. And Torrie, who's one of our private industry partners, is going to talk to you a little bit later on. So my message of an overview, and I do have a few charts, is for you to understand these are people that we deal with and talk with all the time.

I partner with the Highway Patrol that's here, and I see there's a bunch of troopers in

the back guarding the door so you don't try to leave early. I've got my friends here from the Fire Marshal's Office and, of course, Health & Environment. So that is first and foremost who you need to know we are.

Angie Morgan is here with me. She's my deputy for emergency management. All across the board. And I will-- that's my message. We're going to talk about a few other things, but that is our team. We all come together to make the Adjutant General's department. Okay?

All right. We'll walk through a few things that we're doing. Have we got the clicker here? Okay. We had, the Governor mentioned, a cabinet meeting for four hours the first time we've had that and worked that with Mindy and Dick and the folks from Health & Environment, walking through the state cabinet, all of the cabinet officials, a four-hour exercise on continuity of operation. Walking the walk.

What we know will be huge, and you've heard about it before - inform, inform - is what will be the triggers for some kind of public health emergency, which would exercise

the Secretary's extraordinary authorities or a Governor's declaration. What do we do when we have an emergency in Kansas? We form one joint information center so that we have a concise message that goes out across the state. That's one thing we'll do. And we'll stand up, our state emergency operations center, once enough of the counties declare the emergency, so that we can put the resources of the state where they need to go across the nation.

A huge question we get asked all the time: Our planning factors have from the start-- in the five years we've been planning for some kind of pandemic, whether it was a bad bird or now it's a bad bug, it's something bad, I picked up on that, is that we would basically be on our own. So all of our planning, the classic fashion is worst case, we're not planning on a lot of support coming from outside of Kansas with the exception of our industry partners. Okay?

I mean, we are reviewing laws and policies that may need suspended during an outbreak. Do not get your hopes up here. Okay? Don't read too much into that. I'm

being-- I'm being followed by the Superintendent of the Highway Patrol. So the speed limits aren't going to change, all kinds of-- I-- I know you're all disappointed now. You've got to stay for the whole thing.

Here's the reality. Are there things like hours of service that we do all the time? Sure. Are there things like if your driver's license expires, that perhaps those people have been cross-trained to do something else, so you might let your driver's license lapse for a while? Absolutely.

There's a final element of it that-- that Angie likes to tease me about. And that you could potentially change-- this is not for sure now. You could change who is allowed to give a shot. So you could let a veterinarian give a shot. And, of course, everybody thinks that's funny because who do you suppose we would let the veterinarians practice on? The military. That's why you have the military. Exactly. So Angie likes to tell me: Well, you know, we're going to test that out on you National Guard guys. So, unfortunately, that's probably not funny, that's probably actually true.

Okay. But those are the kind of things that we can do as Kansans to apply common sense to get through a pandemic.

Okay. What are we doing? We are working-- we have trained almost 2,000 people in continuity of operations in the Eisenhower Center For Homeland Security. This is what we do. Working with private industry, we-- this is not new to us. The Commission on Emergency Planning Response that's chaired by Chief Taylor has industry members on it so that we have that relationship. It includes a member of the broadcast of the media. Because if you're not going to keep the public in Kansas informed, unless our partners in industry - be the media - do their part to get the information out. Okay? When-- and obviously all of the federal entities that we talk to, and I had an occasion to talk to Secretary Sebelius myself this morning on a couple of other issues. And so her being a governor, I think, is huge to understand how states are going to go about - a former governor - this emergency.

So what are we doing? We're looking at

our essential missions and state functions internally and externally, like I talked about. That's why we would let a veterinarian give a shot. That's why we would potentially suspend hours of service for trucks and things of that nature. We might suspend the weight limits on vehicles. We're looking at those things externally and internally. Services that you'd probably like to have but may not be considered to be essential. That becomes emotional for some-- for some people. But there are things-- there is a pecking order of what's essential. Just like you saw a pecking order of who's going to get the inoculation. Certainly and common sense would tell us there are certain services that are more essential than others.

We are already starting to cross-train people. And I'm sure many of you are also, in your businesses and in the state government. You need to think about that. The way we describe that is this: If you have a single point, if you-- if you have one person who is absolutely the key to your enterprise, have you thought about what would happen if they don't come to work? Okay? That's where you

cross-train somebody to cover them. Okay? And we work with our partners in the counties for their facilities and missions.

What you can do. What I just said, please look at what you're doing now and find the essential things. Educate your work force on the symptoms. Doctor Phillips has already talked about that. Do the right thing, be smart about that. Network with your local emergency management office - never hurts to do that - and your public health department. And we recommend you put a link on your home page to KDHE's home page. Make it as simple as possible for your employees to be informed.

All right. Now, I'm not your personnel director. I would just tell you we would encourage you to allow sick workers to stay home without fear of losing their job. Okay? Flexible leave policies to allow them to stay home to care for family members or children of child care.

Something else you might think about is allowing people to bring their kids to work. Okay? I don't own any of those policies, I'm just telling you how to use common sense, think

of some things that you might want to do. And encourage people to get vaccinated.

Okay. That's really it for us. I want to stress that what we're all about is partnerships. I know not everybody in this room but a lot of people, and people in our agency know them. And we are-- we are trying to mirror the right behaviors to be as prepared as possible. I am convinced as I can be that as big as event this might be, that we come from a state that's been through hard times before, we are not strangers to that. And if we just apply common sense and develop these relationships, no matter what gets thrown at us, we'll bounce back up and we'll drive on. We've done it for 150 some odd years and we'll get through this one as well.

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COLONEL MAPLE: You know, public safety, we're all trained to respond to some kind of disaster or something-- something going on. You know, we know how to do car wrecks, we know how to do fires, we knew-- know how to do explosions, we know how to do those different things. But the H1N1 problem is just a bit

different and requires a lot of-- a lot of different planning.

You know, a different thing, it's a different duration, it's a lot of different things that-- that public safety has to look at. And public safety's role in that is very, very critical. As you've heard from many speakers about information - information, information, information - if we get the word out to the people of the State of Kansas, it will work very, very well.

And we're going to do that in ways that you've heard, and it's going to be a joint information effort, working with a lot of different people. You know, at the Highway Patrol we're all known for wearing the big hat, writing speeding tickets and working wrecks. But in today's world, that mission is considerably different. We are in to Homeland Security. In a lot of different ways we're participating with a lot of our public partners quite differently than we ever have in the past. There are sheriffs and-- and chiefs of police, and we routinely work with the regional Homeland Security councils across the state on

trying to facilitate and build those relationships that the General described. Because without those, there's-- there's no way that we-- any of us have enough to deal with one of these issues. We're all going to be taxed enough. And I don't think any of us are really going to care, if we need the help, who it is that's standing next to us, as long as we're standing together and move forward.

One of the-- one of the really important things to-- about public safety and-- and it has been done and-- and we have a very, very unique situation in Kansas. And I didn't think about it much 'til I got involved in the federal level where we work hand-in-hand together on a regular basis. I see chiefs of police out here, I see sheriffs out here, I see other folks out here. And it's-- it's not uncommon to see a Chief of Police, a sheriff's deputy and a trooper and other folks all wading, wherever we're going, together. And they may have-- very well have a National Guard person right beside them, which we've done routinely.

Now it may be a hub-- public health

person, it may be a veterinarian, it may be many different things. So we are-- at the Highway Patrol have to adjust, you know, to-- to what the needs are in our State of Kansas. And, you know, I'm-- I believe that that is occurring across the state. And you'll see troopers in many different roles, but they are partnership roles. And that's important. As you've seen with the CEPR group and others where you have public/private folks together, that's occurring on a routine basis in a lot of places. So it's-- it's very important.

And there's a lot of-- a lot of work been done on the state level. And as the General noted and others about work on plans and different things, there are pandemic flu plans, we have a state response plan which we participate in, we have a pandemic flu plan, we have a strategic national stockpile plan. And those things are in place. And it came through a lot of work and-- and a lot of cooperation with a whole bunch of different people to pull those off to ensure that we can get things where we need to go.

But the bottom line, as everybody on the

local level will tell you, that problem is going to be right there on the local level. And so a lot of things we need to work on and can work on and do work on routinely is working together on that local level. And that is one of the issues that, you know, the H1N1 group will provide. So when that vaccine gets to a local level, how is going to get done, how is it going to get distributed? You may see your sheriff, you may see your police department, you may see a trooper all there together. And-- and with any-- any great hope that none of that is necessary, because if-- if public safety has to get involved, then there's problems and issues.

So all the planning that's being done outside of law enforcement and other places is critical to the success. And we know how to deal with crowd control, we know how to do some of those different kind of things. But hopefully a lot of that information, a lot of that effort, a lot of that planning, a lot of that coordination, a lot of that cooperation will eliminate the need for public safety, but-- so I would simply say that as a partner

in that process, that-- that the Patrol recognizes and understands. But we are limited too. We have 500 troopers. The General has a limited number of soldiers. I mean, we're all limited. So it's-- it's imperative that we all join together and do that.

And the good thing is that that is happening across Kansas. And we can make a lot of those things happen. And by working together, I think the State of Kansas is in an exceptional position to address the H1N1 item. And, you know, I-- as you all know, we-- we prepare and-- preparedness month is coming. Got to get that plug in there, sir. So we all prepare in Kansas for the stuff we deal with regularly. And that's severe weather; we get tornados, we get floods, we get snowstorms, we get ice storms. The H1N1 thing is significantly different than that, but we know how to prepare in Kansas.

And that's one of the things that as you're seeing across the state and here today, the level of commitments that's there to address the issue, and that preparation will position us to adequately deal with that.

And with that in mind, I'd just like to thank you all and-- thank you all for coming, and I appreciate the opportunity to speak with you.

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COMMISSIONER POSNEY: This is a great opportunity for us to chat about something that's very, very important. And absolutely for the first time schools are going to be the-- probably the most critical piece that we have to center our attention on.

We as the Kansas State Department of Education has collaborated with the Kansas Department of Health & Environment to address the potential concerns specifically involving schools, as we work to combat the spread of H1N1. To this end, we have recently launched the H1N1 web page on the KSDE website to provide timely information to the schools. This web page also links to all the other websites to KDHE and to CDC. To access this website, you can go to ksde.org and click on the rotating icon that's entitled, "H1N1 Information For Schools" right in the middle of the home page. This will take you directly to

the site. It's really important for all of us to really take precautionary measures to prevent the spread of the virus. Basic hygiene practices are the key, as Jason has shared with you.

My graphic arts team has designed a poster displaying the basic hygiene practices. And I have my lovely Vanna White, Karla, displaying the poster. And these can be downloaded by any and all of the districts for use in their schools.

The practices that we're asking schools to adhere to, and I know you've heard some of these before, but it's really important that we go over them again and again. Covering all of our coughs and sneezes, washing hands frequently, especially after coughing, sneezing and blowing one's nose. Making sure that adequate facilities and time are made available to everyone in school for frequent hand-washing. Alcohol-based sanitizers I know have been placed in all of the schools.

We have to let our kids know to avoid touching their nose, mouth or eyes, recognizing that flu viruses can be transmitted to hands

when infectious droplets are left on hard surfaces. And we know that schools are spending a considerable amount of time with routine cleaning of high-traffic surfaces like doorknobs, stair railing, student desks and so forth. And regular detergent cleansers are sufficient and special cleaning with beach is not required. And finally, disposing of all contaminated tissues properly.

There were several lessons that we learned from the spring outbreak. One is, closing schools is not the best option for control of this infection. For now, we're suggesting several simple steps to prevent most schools from closing as cases occur, such as-- or however, if absenteeism in any particular school is too large, school dismissal may be necessary.

Earlier dismissal also may be necessary in schools that serve pregnant or medically-fragile students if they cannot be protected. Decisions should be made in collaboration with all the local and state health officials. Dismissal should be for five to seven days, after which the situation should

be re-assessed. Parents should be encouraged to keep sick students at home and inform parents that ill students will not be permitted to remain in school.

They're going to develop a sick room concept where space is set aside to separate those who have flu-like symptoms until they can be sent home. The space should not be in areas used for other purposes, and with limited staff assigned to care for these ill students. Schools should consider purchasing surgical masks. Dust masks work very well for both staff and ill students who are in the room. Monitor the daily attendance rate at the school in district level and report increases in absence rates related to respiratory illness to the local health department. Collaborate with the local health department and school nurses regarding surveillance, health promotion, and preventative measures.

A district plan should be developed to address such issues as the possibility of large numbers of staff unable to report for work, and consider an alternative educational plan if students are isolated or if school is closed.

And one question that we get over and over again is: If you do have to close school, are you still obligated to provide the 1,116 hours worth of school? The answer is yes, because you have until June 30th to meet those hours. And I know that's not exactly the answer you wanted to hear, but that's still the case.

As educators, we know that we need to solicit the help and support of our students' parents if we really want to control the spread of this virus. We have asked districts and schools to share the following recommendations with parents. Here's what your school needs you and all parents to do. Keep sick children home. We can't say that enough. Don't send them to school or take them anywhere else except to receive medical care.

Ill children should stay home until they are fever-free without the use of fever-reducing medicine like Tylenol or Ibuprofen for 24 hours or more. Plan for the possibility that you will be called to pick up your child from school if he or she gets sick while in school. Schools are setting aside

special sick rooms for students who show-- show signs of illness to use until they are taken home.

Cover your mouth and nose with a tissue when coughing or sneezing and insist that your children do the same. If you don't have a tissue, as Jason shared, cough or sneeze into the bend of your elbow. I didn't know it was called-- what did you refer to it as?

DOCTOR EBERHART-PHILLIPS: The Dracula.

COMMISSIONER POSNEY: Oh, the Dracula. That's-- that's pretty good. The kids will relate to that. Wash your hands often with soap and water, especially after coughing or sneezing, and see that your children follow your example. Alcohol-based hand cleaners will also work.

This year all schools will make sure the children have the time and places to wash their hands often during the school day. Remind children to avoid touching their eyes, nose, or mouth. Germs are spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

Make sure that your children practice other good health habits. See that they get plenty of sleep, get exercise, drink plenty of fluids, and eat healthy foods. Get your child vaccinated for seasonal flu soon. See that your child also receives the H1N1 vaccine when it becomes available this fall. And stay informed. And you've heard this message over and over again. Watch for information from your child's school. The simple advice is: Get your rest, eat healthy foods, stay home, and take care of yourself.

My staff has also prepared magnets and bookmarks and other things that the schools can download that-- and parents can put these on their refrigerators as a quick reminder. They're-- we left those out on the-- the front table as you registered, so please feel free to take one home with you. These can also be downloaded from the H1N1 web page on the KSDE website to be given to parents.

We have also asked districts to cooperate with local health departments in scheduling H1N1 immunizations at schools in the district. This will help to ensure that all children have

access to vaccinations.

Limiting the spread of flu in schools during a pandemic requires a brand-new perspective. We need to expect the unexpected. Parents, teachers, and administrators alike need to work hard to keep schools open and be ready if schools must close suddenly. Students and staff have to give up the notion that absences are to be avoided at all costs. Perfect attendance should not be the goal. Above all, we must be adaptable to rapid change. Working together, we really can slow the spread of pandemic flu in Kansas. Thank you.

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MR. MATHES: What I'm going to talk about a little bit is, is what we've done in our district. I'm not going to give you our plan, but you can see our plan at www.usd345.com. Go to "Health Services" and then "Communicable Diseases." Repeat that. www.usd345.com, Health Services, Communicable Diseases.

We've had a pandemic flu plan in place for about five years now. Feel free to take

whatever you can use from that, adapt it to your situation. Use the whole thing if you want. That's what it's there for.

We think that there are two main strategies that we need to focus on right now. One is reducing the spread of the virus within-- within the schools and our community. And two, sustaining our educational functions.

Now, I'm going to go over a-- a few brief-- a brief synopsis of some of the things that we've done this year. Number one, we reviewed our plan. I know that-- I see a lot of my colleagues out there, and I know we've all got crisis plans and-- and maybe some-- some pandemic flu plans. But you know-- do you know where they're at? Yeah. Make sure you've gone over them and you've gone over them with your staff.

Update your contact information. That means all of your kids, all of your kids' contacts. If you have a student who gets sick at school and you don't have a way to get ahold of a parent, what are you going to do? You need to make sure that all of those are updated and get that done right now.

Identify points of contact within your county. We have contacts with the Shawnee County Health Agency, we know who to contact. And develop a plan to cover key staffing positions. We have one person who does payroll. If that person gets sick, what are you going to do? I don't want a bunch of sick people coming to my office mad because they didn't get their check. Make sure that you cross-train your staff so they know how to do different types of necessary functions within your district.

Like Doctor Posney said, educate and encourage sick students and sick staff to stay at home. You know, teachers are the best and the worst. When they get sick, they don't stay home. They got to come take care of their kids at school. We have to encourage them to stay home. With that, your plan needs to have something to address what your absentee policies are. They may not have any sick leave left. How are you going to address that? We still don't want them coming to school. What's in your plan?

Again, identify a separate room or a

seclusion room for students who are identified as-- as sick. Make sure that you've got someplace where if a student has symptoms, you have a place to put them until someone can come and get them. Be prepared with protective gear. If you haven't purchased masks and gloves, make sure that you have those available and your staff knows where they're at and when to use them.

Establish an absence tracking system. In our district we have a system that at the end of each day I can tell what percentage of students were absent. And of those absentees, I can tell what percentage had flu symptoms. So as we track that, we can start to-- to see some seriousness or not serious and contact the health agency. You know, are we going to close? That's not my call, unless it becomes a situation where we don't have enough staff to continue on. In your plan, does it say how you're going to carry out your 1,116 hours to complete your educational responsibilities.

I think it's very important for you to develop communication tools. You may have this plan in place, but does your community know

about it? Does your staff know about it? How are you going to communicate these things and when are you going to do it? Are you going to do it when the crisis hits, or have you already got in place a plan that has been communicated and everybody knows already: If I get sick, I'm going to have enough sick days, I'm still going to get paid, I can stay home.

We piloted last year flu vaccinations within our buildings. I think if-- if this becomes a serious pandemic, schools are going to be looked at to be places of immunization. Do you have a plan in place that your school can be used? We were-- we piloted last year vaccinating about half of our students in the schools and about 60 percent of our staff right there in the school. Something you may want to consider.

And most importantly, provide educational activities, teaching your kids and your staff proper hygiene. Teach them, give them-- give them activities of how to wash their hands. You know, a lot of kids don't know how to wash their hands, a lot of adults don't know how to wash their hands. How long should you wash

their hands?

Do you have the alcohol sanitizers, which-- which was an extra cost, by the way. I hope that-- that with the cuts that have come across superintendents, that it-- that it wasn't the alcohol sanitizers and it wasn't your nurses that got cut, because-- I had to get that in there. Sorry.

Again, if you have any questions, go to our website. There's a lot of information there, a lot of educational websites that you can go to. If we have students who get sick, they can go to that website, download educational materials while they're absent so their educational process isn't interrupted.

I appreciate everyone being here. If-- if we can be of any help, we're here. Thank you.

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DOCTOR COOLEY: What I hope to do today is to give you the perspective from the primary care provider. And just as Secretary Bremby said, I-- I'm at the front lines. So I'm the one that's going to be there.

First off, just a couple of things that

I think have already been gone over, but it doesn't hurt to-- to re-emphasize them. When we're talking about pandemic flus, one of the things to remember is this is novel flu virus so that we're going to see anywheres from 25 to 40 percent of the population that may be infected from this. That's compared to, say, a-- a seasonal flu virus in which maybe 10 to 15 percent.

So you can see we're-- we're at least doubling and maybe even tripling the number of people that are going to be infected. When you do that, just think about how busy it is during the regular flu season for your primary care providers. And now just imagine what it's going to be like when you have two to three times more people.

The other thing that's been mentioned is that pandemic flus do come in waves. And the waves vary in times. They may take up to a number of years. But in 1918, for example, most of all the damage that was done by that pandemic occurred in about a 12 to 18-month period.

The other thing about the waves that you

need to remember is, is that a lot of times these are-- they're compressed into about a four to six-week period. And again, imagine what it's like for the primary care provider when all of these patients are coming in in that very short period of time.

The other-- last thing that I want to emphasize on pandemics is that there really is a shift in the infection rates, in the morbidity rates, and in the mortality rates to a much younger population. And it's-- it's my population - I'm a pediatrician - it's my population that really gets the brunt of the disease burden.

Oops. Sorry. This is a-- a slide that I kind of want you to all look at. The top graph there, if you see that dotted line on the bottom there, that's typical of seasonal flu. And what you see-- this is mortality. And what you see is that most of the deaths occur in the very young and in the very old. And it's called a J-shaped curve. If you can kind of draw that out, you can see where it forms a J.

Now, in 1918 with the Spanish flu, you'll see that what happened, that's-- this is now

the top solid line, what you see is that there was a-- a large increase in young adults. And these were healthy young adults. And it forms what we call a-- a W-curve. And you can't read it very well, but in the yellow there it says that these trends we're also seen in the '57 and '68 pandemics also. And just as a-- additional information, if you look at that bottom, just to show you why public health officials and why healthcare providers are worried, just look at that bottom curve. What that bottom curve shows you is that that is the life expectancy. And how much that dropped just from the Spanish flu and the influenza, it dropped dramatically. I mean, the-- you can see that dip, and then it came back up. So this-- when we talk about pandemic flus, these are very, very serious things.

Okay. There were three pandemics in the 20th Century. The 1918 was an H1N1 virus, same as what-- what we're talking about now. It was very severe. And the number of excess deaths was greater than 500,000. When we talk about excess-- excess deaths, what we're really talking about is-- is-- and it's an important

number because what it's showing you is how many people died more than you would have expected from influenza seasonally. So while it might be hard for us to-- to know exactly how many people in 1918 died, we know that, for example, the total deaths were somewhere over 600,000. That we-- well over a half million of those were just due to that pandemic and were in excess.

And you look in '57, it was a more moderate pandemic. It was all-- it was an H2N2, a little bit different, and the excess number of deaths was greater than 60,000. And then in '68, which we consider a mild flu, we still had over 40,000 people who died in excess of what we normally see. Normally from seasonal flu we'll experience about 35,000 deaths a year. So seasonal flu itself is a serious illness, and we sometimes forget that.

So let's look at H1N1 from 2009. As you know, we've had about a million cases estimated so far. And by the-- the 1 percent rule, Kansas has probably had about 10,000 cases. We know that we've seen more flu activity in the summer than we usually see. The highest

infection rates tend to be in the 5 to 24-year age bracket and the zero to four years. That's next. Those may be a little bit different numbers than what Doctor Eberhart-Phillips showed you or it may look a little different, they're not. What I'm talking about is-- is rate as opposed to the absolute numbers. So what you, again, see is that-- that our younger individuals are the ones who tend to get more serious effects from this.

The highest hospitalization rate is in the zero to four-year age bracket. Again, my population. And the next is in the 5 to 24 year age. So far, the highest mortality has been in that 25 to 49-year age bracket. And think about that in view of that W-curve that I showed you. The same thing, isn't it?

Now, so far most evidence has been that this has been a mild disease. Let's just hope that it stays that way. Okay. Well, why would we worry then if it's-- it's a mild disease? First off, even in a mild pandemic, just the sheer number alone can easily overwhelm our system.

As I said, if you-- you know, during the

regular seasonal flu season, most physician's offices are extremely busy. Now you double or the triple the number of patients that they may be forced to see or asked to see, and you can see how-- how this can overwhelm it. Think about our emergency rooms, too.

The virus could mutate into a more virulent strain at any time. And this is what happened in 1918. From the initial wave, which was very mild, it-- it mutated into a very, very serious infection, causing all those deaths. And then you still have to remember that this may be a mild disease, but we have seen reports that indicate that severe disease can be seen. And this was just in-- two weeks ago in the New England Journal of Medicine in the August 13th issue.

There were two articles that looked at the experience in Mexico. Now, what we saw was that - just as we have been worried about - that there were cases of young, healthy adults who have died from severe respiratory disease, so this can be very serious even in a mild form.

Now, we've talked a little bit about

Kansas projections. And this is from the Kansas Pandemic Influenza Preparedness Response Plan, and you've heard about 550, maybe a million people may be infected. Think of this, though. 200,000 to maybe even a half million outpatient visits may be involved here. Again, overwhelming our system. Between 4,600 and 10,000 hospitalizations. Again, just think of the sheer numbers that may be involved. And finally, we may have between 1,100 and 2,500 deaths. That's all total numbers.

But one of the things that I emphasize was how that this disease burden seems to really occur more in the younger populations. And so one of the things I tried to look at was finding out, so what's that going to mean to me as a pediatrician? And it's really hard to find out that information. But one of the things I came across was this article, actually it was from a workshop put on by the Institute of Medicine on the pandemic flu. And this is-- it looked at the economic impact of pandemic influenza. And they actually had calculated rates based on age of what you could expect, from severe to mild pandemics.

And if you projected this in Kansas populations, this is the kind of things that we would see for pediatrics, 120 to 170,000 pediatric outpatient visits. I can tell you my office would be swamped. Okay? 226 to 2,300 pediatric hospitalizations. How many pediatric hospital beds do we have in the state? And finally, 15 to upwards of 400 pediatric deaths.

This morning I went on the website of the CDC, I just kind of wanted to get some information to find out just how many pediatric deaths we've seen so far. We've seen 37 pediatric deaths from H1N1. That may not sound like a lot, but I want you to realize that the average number of pediatric deaths for the last three years from seasonal flu has averaged about 70 a year. Okay? We haven't even seen the way-- the big wave yet for this disease, but yet we've already seen 37 pediatric deaths. So this potentially can be a very, very serious illness.

Okay. Pediatric concerns. I told you about these. Average age we-- we heard about is 17, with 80 percent of the cases occurring in persons less than 35 years of age. And

children are a major source of spread of influenza. They shed the virus much longer, they have higher levels of virus that they shed. And they're in big groups. Schools, daycares, the mall, you know, they congregate, folks. And this is why it's very important that we have vaccination of pediatric age groups. And that's a high priority. Because these are the one-- these are the-- the population that really tends to spread this infection.

Also, and I think this has been pointed out, a large amount of our work force is going to be infected just by children that are sick because somebody has to care for them. If an adult is sick, many times they can manage their-- on their own at home. But when a child is sick, they can't.

Okay. What are the concerns of-- of a provider such as me. Well, first off, the increased number of outpatient visits. I've mentioned that. We also have to consider that there's going to be a delay in postponing just routine preventative care. We have to think about do we want to do routine check-ups,

routine vaccinations. Do we want to do that when we have sick kids in our office?

You know, there are ways that maybe we can work around that with well and sick waiting rooms. But the truth of the matter is, is that-- that we may have to seriously consider whether we either postpone preventative care or-- or really just kind of decrease the amount that we're able to do.

Offices are going to be overwhelmed with phone calls. I'm already-- my office is already getting phone calls about H1N1. We get a number of them a day, and we haven't even seen really any high numbers yet. This is really going to require a lot of personnel and it's going to tie up your office visit-- or your office flow.

Staff illnesses. Okay? Are-- what-- how many-- how am I going to be able to maintain my office and seeing the patients that need to be seen if my nurses are sick or if my reception staff is sick? What am I going to do for that? Not only that, but what about my staff who now have to go home and take care of their sick kids? These are all things that we have to

think about and-- and we have to-- to plan for as providers.

Vaccine distribution. We're buying an extra refrigerator, quite frankly, in my office so that we can give the vaccine. I don't know of too many places that may be doing that, there may be a lot, I don't know, but-- and here's something that I think is very important. I-- we talked about how important it is to vaccinate school-aged children. I don't think that my office-- and I give vaccines to a lot of kids. I don't think my office could handle if I not only had to give the vaccines to the kids that are younger than-- than, you know, school-age and in addition to the school-age kids. So I think it's vitally important that we have the schools as a source for giving out vaccine.

The other thing you need to remember about Kansas is there's only about 50 percent of the providers that actually give out vaccines. The rest of it is done by public health. And you can imagine how they're going to be overwhelmed anyway, and especially when they have to give extra vaccines. So I really

think that it's important that we utilize our schools as a source for giving out vaccines.

And finally, communication with public health. I've been very impressed with KDHE as far as their attempts to contact providers. Unfortunately, I think-- and Doctor Eberhart-Phillips can protest to this, it's very difficult sometimes to-- to get the word out or to-- to give messages to providers. And, you know, you would think that in this day and age, that all you have to do is send out an e-mail and everybody would get it. Unfortunately, I think with some of our providers, you know, they-- they're not in the IT age yet. They-- they don't read their e-mails very often. And so it's become very difficult.

We have to really work on getting primary care providers to start paying attention to what comes out from KDHE in these messages because they've been excellent and they really give us important information. So I think communication with our public health sector is really vital.

Okay. Other concerns. Let's look at

just the hospitals, because I mentioned some of the things about the number of beds we're having. First off, emergency rooms. Unfortunately, most of the-- or not most, but a large number of people in the United States do not have a medical home, they don't have a primary care provider that they can go to. And so the result is going to be that they're going to utilize emergency rooms. And again, think about the-- the stress that that's going to put on our emergency rooms. Especially when it's important that they do what they're trained to do, and that's take care of our critical patients.

Hospital surge capacities. How many of you that are involved in hospital planning have made plans for handling the increased surge? How many of you thought about pediatric patients either, I might add. Pediatric beds I mentioned.

Labor and delivery. We have to make sure that our labor and delivery departments are thinking about this, too. You can't deliver a mother-to-be who has influenza-- you should not be delivering them in the regular labor and

delivery department. You should not be exposing other pregnant women to the flu. So they have to work about-- think about these kind of situations.

ICU beds. You heard about the experience in Australia where they ran into problems with things like ventilators and ICU beds. You know, these are the things that our hospital planners need to be taking into consideration. And finally, those transfer agreements where if you get full, who are you going to send patients to. Again, pediatrics, if you don't manage pediatric patients, who are you going to send them to?

That's all gloom and doom, but there are some-- some things that maybe will help mitigate this whole process. And one is, first off, that maybe-- hopefully the virus may stay very mild. And if that's the case, then-- then, you know, hopefully we won't have the numbers that we've been seeing-- talking about.

The other thing is that maybe the vaccine will be around enough and will be effective enough that it will reduce the numbers. Most of these projections that we have haven't

really taken into effect-- or taken into account the effect that the vaccine may have in decreasing the numbers of patients that are going to develop influenza.

We have excellent communication systems for public information. We've talked about these things. I think the public is becoming more aware of the importance of proper cough technique, of washing their hands. We have-- we have now antiseptic cleansers where you don't have to have soap and water to clean your hands effectively. So we have a lot of different means that we can do to help with mitigating some of these problems, especially in the public health field.

And finally, what effect are antiviral medications going to have? You know, we have to be prudent in their use, but they certainly can help, especially on our high-risk patients.

And finally, this is a picture of Camp Funston. I know Doctor Eberhart-Phillips had this picture, too. Camp Funston was in Fort Riley, 1918. And you can see this is the effect from the-- the Spanish influenza, which, by the way, may have started in Kansas. At

least some authors say that. Let's hope that-- Haskell County, yeah. Let's hope that-- that the-- the coming season that we don't see this type of a-- a problem with the influenza. And I want to thank you.

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MS. BEHNKE-SPIEGELHALTER: Good afternoon everyone, and thank you for the opportunity to be here today. And I apologize to those of you who have heard me speak frequently, as we have done a number of these briefings in the last several months and-- and through the ongoing public/private partnership that we support with the State of Kansas.

So talking about H1N1, we expect that everything will continue to-- to operate at near normal levels. This is a little different than our traditional all-hazards approach where we're looking at something like a smoking hole in the ground or a significant impact to our infrastructure, right, where the physical elements have been-- have been removed.

So back in 2005, we did put together a core team to address pandemic preparedness, and we did learn a lot. In particular, teleworking

is a big piece of our business continuity plan. And we'll talk a little bit more about what we learned as a communications provider and then what impact that had on our own business continuity plans.

Monitoring status and developments through the World Health Organization and the CDC. Our global network operations center in New-- Bedminster, New Jersey, is our incident command system, our primary point of contact for all emergency events. And we do work very closely and keep those developments communicated to our employees.

All essential work functions within AT&T have been documented. And again, we have a different plan for pan flu. All-hazards planning was the primary approach in years past, and we've taken a different turn to look at pandemic planning.

We also exercise-- test, train, and exercise our plans regularly. At a minimum of four times a year we are going out, staging our assets, our equipment, our resources, and making sure that all of those business processes, those key functions, are able to

continue to work regardless of that situation.

They're also reviewed and supplemented accordingly. Lessons learned. That's a big part of our testing, training, and exercise is coming back on the back end and understanding what our pain points are, where we were not able to meet commitments, and then come back and-- and adjust for those. And again in 2005, during the Avian bird flu, we found out that internally we needed much more capacity to support our teleworkers.

And then lastly, primary vendors have been contacted and surveyed to determine what their plans are and if they will be able to support us during a pandemic. We talk about inter-- interdependencies regularly. And whether or not it's pan flu or a hurricane or some sort of malicious attack against our-- our country, we still have to understand what those interdependencies are.

So pandemic preparedness methodology, again we're building on our core business continuity or our all-hazards approach to planning. These are some of our corporate tactical planning teams. Each one of these

organizations has a business continuity plan or OBCP, organizational business continuity plan. What are your essential functions? What's required to complete those tasks? Who are the people required to complete those tasks? And we also talk a lot about cross-training. I've heard that come up a couple of times today. A very important part of our-- of our preparedness planning.

I get a lot of questions about what are some of the measures that we would implement during a pandemic, are we going to be issuing surgical masks. No. We have evaluated the N-95 respirators. And I personally have not had an opportunity to test those, they are not something that we plan on incorporating as part of our regular pan flu response. If anything, we would look at putting masks on those that are sick, in lieu of trying to put a mask on everyone who is not sick.

And going back to some of the standard rules that we've heard here today; if they're sick, send them home. Right? Most of our strategy is around social distancing. We do have some situations where we will have

contractors sitting two to a cube or we might have a bull-- a bullpen type arena where folks are being dispatched from and creating environments where they can practice social distancing techniques.

We also enforced-- not enforce, but we promote hand-washing. We provide sanitizing wipes for keyboards, for telephones, as well as things like Purell and-- and the-- the hand sanitizers.

We would tweak our plans if this turns into something that has a higher mortality rate. So our plans would-- would change based on the guidelines that we receive from WHO and CDC. We take much of our strategy and policy from what's communicated by our federal partners.

Normal absentee policies apply. Whether that employee is taking paid time off or non-- unpaid leave of absence, we do expect that those policies will continue to be in place and with very little tweaking.

We would consider taking temperatures. That's not something that we've gotten into to date, but it is something that we're

researching and we're looking at different technologies on how that would-- that would incorporate into our day-to-day business. We are not stockpiling anti-virals. We are not asking people to get vaccines. We encourage them to follow the guidelines as they are being initiated, but we do not plan to require our employees to go out and get vaccines.

I will tell you that we have a medical staff that's part of our Network Disaster Recovery Organization. So as those folks are going into an affected area, for example, and we've got 100 folks that need tetanus shots before they go into a scene, we do have healthcare professionals that can provide those types of-- those types of services. But at this point no stockpiling, no attempts to administer those vaccines.

We do, General Bunting, have an invitation to you all to use our facilities as needed if you need points of distribution down the road for things like that. We want to support you guys through that public/private partnership.

So those are some of the preventative

measures that we're employing. Because we work in such a virtualized environment to begin with, we're in a little different place than a lot of our business partners. I'm usually out talking to our-- our partners about their business continuity plans, rather than our own business continuity plans. So it's-- it's interesting to have the shoe on the other foot today.

So talking about a pandemic scenario; what I thought I would do is break this down into two categories, services and then network impacts. So impact to our services, our ability to provide services for our customers, and then what that impact is going to be into our network without getting too much into the whole telecommunications dialogue today, because I know you're looking for more of an overall industry perspective on what-- what folks are doing.

So service impacts could come at customer connections. Again, I fall back to teleworking being one of the primary COOP components relative to pan flu preparedness. So things like dial-up; I don't know how many of us are

still using dial-up, but that is still an access method. DSL; probably one of our biggest concerns in terms of what people are going to need in order to support teleworking. Private line dedicated access. Again, each one of these having different costs and different band width capabilities and service level agreements associated with those. But from a services perspective being able to support, repair, and installation of new orders.

The network backbone and design; the IP network is extremely scaleable and don't anticipate a significant impact there. It can have-- handle a high surge in-- in traffic, as well as our wireless towers. Again, they are provisioned for more capacity than that area generally needs, and we can bring in additional services as needed.

From a services perspective, our managed services, our hosted offering, hosted IP, hosted BPN, our global access network, all of those things, again, operate in a highly-virtualized environment, so we're able to shift those resources very quickly. And we'll talk about some of that on the back end

when we talk about network.

Field technical support. Again, as we go back let's take the DSL as an example. Because people do need access at their homes or their-- their virtual offices during a pandemic, this is the one red flag that goes up for us. Is if we do have a situation where a pandemic is coming into a region and it's beginning to affect an area and people have not planned appropriately and they're calling up and saying: I need to get DSL in, and a normal DSL, you know, lead time is-- is 30 days, right, you guys do the math. If we're talking four weeks and it's rolling, right, how-- how quickly are we going to be able to get those services in?

So cross-training, taking folks that have traditionally maybe been in repair and moving them over to installation services. You'll see a significant amount of cross-training within our organizations.

Call centers. Again, this is something that we actually practice almost daily as-- as we have to redirect calls based on-- in particular hurricane season as it hits our call

centers along a coastal region and having to transfer those calls to another center. For us that is-- that is-- is-- is very seamless to-- to the end users. And if we have a call center that is overwhelmed with illness, we'll just simply close it. It's easier for us to redirect those calls to another call center than actually try to get those agents in a work-from-home environment.

So we look back at essential functions and making sure that those people that have essential functions that are going to be working from home have multiple access points to the network. And again, that could mean the DSL, the dial-up, the private line, those types of services.

And our people are going to be sick, too. So we're going to have to prioritize that work. So depending on, again, the agencies that we're working with, the mission criticality of the-- of the-- of the customer need, we will prioritize based on that.

And then touching again on that lesson learned. Back in 2005, in looking at the Avian flu and looking at our-- our teleworking

situation and realizing, gosh, if we start pushing that number of folks into a virtual office environment, we don't have enough VPN connectivity to support that number of users. So we made significant investments in our network to be able to support that. But again, we're more concerned about the general public and those folks understanding what's required there. So we can-- we can roll out tens of thousands of internal teleworking arrangements very, very quickly.

All right. Now, moving into network impacts. Some of this is-- is fairly common sense. Most of you know that internet traffic peaks in the evening hours, you know, after school when the kids come home in the evenings when most folks are-- are done for their day. We could see this shift to daytime hours as many people are telecommuting.

Any significant shift could result in some congestion. Anybody that's been through a major disaster or any kind of regionalized or localized incident has maybe experienced "all circuits are busy" or you get a fast busy signal when you try to call through. That's

just the nature of the-- of the network and the size of-- of our planet these days, but especially at the aggregation points near residential communities or large, urban areas. And again, I don't want to say choke point. Congestion point, right, as we're narrowing down and delivering those services into a regional area, what's that switch like? Can that capacity be maintained throughout that area?

And user experience will also be affected by community level characteristics, such as broadband access penetration and employment demographics. So how many people have broadband in your community? How many people in your community already work from a virtual office environment, right? How many people in your community have children that could be on the internet? So there's a number of variables that will play into what those expectations are at the local level.

So we do a lot of modeling in order to evaluate the impacts of a pandemic. And again, a lot of this has been built upon the all-hazards approach that we have already

employed for a number of years, not-- not-- not a lot of new things here, but just so you guys understand as a carrier some of the-- the things that we can implement to help mitigate the overall impact of a pandemic and still deliver some service level to our-- to our customers.

So these alternatives might include network management controls. This would be the redirecting of traffic, inbound and outbound. So as you see in a hurricane situation where they will change the-- the highway system to all one way versus incoming and outgoing, we can do the same things with our network.

Another new capability that we have: Bandwidth capping. Okay? So let's say that you've got a-- a kid on your street that's playing X-Box and downloading movies and it's dragging the rest of the-- the rest of that community down, right, from being able to perform mission-critical apps. Those are things that we look at and that we can see down to an individual line. And if push comes to shove and it is affecting, again, some kind of mission-critical service, we'll-- we'll call

the guy. Hey, did you know... and if not, we'll take him out. Now, we haven't had to do that. General, I'm calling your guys.

We will take them out of the network temporarily. Or-- or we will-- we will-- we will throttle-- we will throttle that bandwidth so that all users are having a common experience. So it's not that you have all and you have none, it's that we're going to level that playing field for a period of time.

Now, I don't want you guys running out here going, you know, AT&T is getting into my business and they're going to pull me out of the network. It-- this is regulatory, there is a lot of hoops that we would have to jump through before we did anything like that. But from a capabilities perspective, that is something that is now available to the industry. And we really do have to consider that as we have so many different ways that-- that that bandwidth can be hogged.

Network grooming. This includes the rearrangement of network design to minimize congestion. So in real-time, moving points on a map to where that traffic is going, which

router, which switch is it going to. Again, in order to mitigate whatever that localized impact is that you're experiencing.

And then targeted capacity augmentation, I touched on this earlier, being able to bring in additional capacity. And I don't want to get too technical, but, you know, additional T1, additional OC3, bigger pipes into an affected area for a temporary period of time to boost capacity in that affected region.

Long-term strategy. We do get a lot of questions about this from a communications perspective. And it's not on the slide, but it would be priority of service. And most of you I believe are familiar with the National Communications System, the government GETS/WPS, TSP, all of those priority of the services.

Teleworking raises the-- the red flag again that we do not have a data priority of service. Okay? So today you can get voice priority, you cannot get data priority. And that's-- that's where the rubber meets the road when we start talking about teleworking and that ability to-- to share data. And I know that these guys know how important that is when

it comes to their mission-critical ops.

I will tell you that the National Communication System, the Department of Homeland Security, they're under DHS, back in 2006, 2007 basically put an RFP out to the industry and said: What is going-- what is it going to take to achieve data priority? What do you all need from us? What do you need to incorporate into your system to achieve data priority of service like we're able to offer with all of the voice services? All of the carriers responded to that: Here's what we need. They continue to look at that, evaluate it. We hope that by the end of the year we actually see a recommendation in terms of all of those requirements, the costs associated with implementing those changes, and then hope to get a bill passed that would fund that. So 2011, 2012, right? It's not going to help us in the short-term.

So there are some best practices that we get into in terms of, you know, sending files late at night, large files, large batches that you would, you know, be normally sending out during business hours, that you're deferring

those to nights and weekends. Again, balancing those mission-critical essential functions with: I need to get it there, but I don't care when it gets there. So next generation data priority of service is a ways off and it is something that you definitely want to consider when you're-- when you're putting your plans together.

All right. And in summary, again, we feel like we've taken all the appropriate actions to ensure that we can continue services for our customers. We've practiced this for a long time. And we've had what I will call worse situations in terms of that smoking hole in the ground where we're having to come in and replace physical infrastructure over people. We are very fortunate, being the size of company that we are, having the depth and breadth of resources that we do, through cross-training and through-- through network redesign that we can really handle most of what we expect will come of this.

A variety of strategies and contingency plans. Telework, again, being one of those key components, along with social distancing, and

then that we have all of the appropriate supplies, personal protective equipment, and even additional spares. You know, we talked about the demand for new services like DSL, making sure that we have enough DSL modems and routers and that we can get those on time. And what happens if FedEx is not able to ship those to us. So again, looking at that entire ecosystem in terms of being able to provide-- provide all of those services.

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SECRETARY BREMBY: Let's start with a question for Doctor Eberhart-Phillips. There's a question about whether there's a resistance to antivirals or Tamiflu.

DOCTOR EBERHART-PHILLIPS: Can you hear me?

SECRETARY BREMBY: It's being unmuted, I think. Let's try it.

DOCTOR EBERHART-PHILLIPS: Okay. The question is about antiviral drugs, Tamiflu Relenza, the two drugs that this organism remains sensitive to. There have been various sporadic reports of resistance around the world. The most recent in the United States

just last week. It's something that-- important for us to watch. But at the moment, we can be virtually certain that a-- a patient with this illness could be treated with these drugs.

Now, it's a different question if we should be treating every case with these drugs. It's-- they-- they represent a very precious resource for us if-- if we're anticipating a large pandemic wave in the future. And we don't want to squander that now, and we certainly don't want to overuse the drug in a way that would promote resistance in the future.

So the advice that we have given medical providers around the state is to use this resource judiciously, to reserve it for patients who are at risk of serious complications because they have underlying chronic medical conditions or are pregnant and-- or those who-- who clearly are manifesting severe disease. But most people, who are otherwise healthy, who have only mild illness can treat this by resting, drinking lots of fluids, and waiting it out for the few

days it will take to get well.

SECRETARY BREMBY: Okay. Next question for General Bunting. Are there plans to activate EOCs and JICs virtually? There may be an issue about bringing people together during a disease outbreak.

GENERAL BUNTING: Yes, there's a means to do that. And I think Torrie had made some really good points about it. What we have to anticipate is whether or not the system will allow for that. If I was to push back on an issue about continuity of operations or-- to all of you is, in your own-- inside your own company you need to understand-- ask yourself how many of your people if they stay home and dial back in remotely before your system collectively can't support that. So we're-- we're open to that idea, because-- but we're also open to-- to going back to technology that many of us remember years ago as a way to communicate.

You know, there's the internet and there's the good old highway net. And it could be that the day comes that that's how we communicate. And maybe once or twice a day is

the only time you get the updates, because the other systems may or may not be there to support that. But I think all of us need to look hard at that. That's how we are now saying we expect most people to be and keep informed is to go to our websites. And we're certainly going to be in a jam if they're not up and available. You know, they could-- you can go down the stair-stepping of, okay, I told you to go to a website, but you can't get to it. Then we've got to hope our other partners in-- in communication step up as well.

So the answer is yes, understanding the limitations of that, and especially when the system itself may be over-- overtaxed by how many people are trying to do the same thing.

SECRETARY BREMBY: Okay. Question for Doctor Cooley. I understand that death from H1N1 may be caused by respiratory distress such as pneumonia. Would it be beneficial to have a pneumonia vaccine? And I understand children 10 and under have pneumonia vaccine already.

DOCTOR COOLEY: Yeah, usually there's the main vaccine against pneumonia. There's--

is the-- the one against pneumococcal pneumonia. And children should routinely receive that under-- usually if they're under about five years of age, whether or not a pneumo-- the other pneumococcal vaccine would be of any benefit. I don't think I've seen anything right now that has said that. But children certainly get vaccines against significant bacterial infections such pneumococcal infections and also haemophilus infections which also can cause-- cause pneumonia.

The thing about the ones is that you-- one of the risks you run into is that the deaths that they can get from pneumonia are from secondary bacterial infections. They still can get infections from the virus itself, too, and there's no vaccine that's going to prevent that other than hopefully your H1N1 vaccine.

SECRETARY BREMBY: Okay. Okay. A question for Claudia. Can you address how you plan to get parental consent easily at a school-based vaccination clinic or at a daycare. Do you have a plan in place for this?

MS. BLACKBURN: I believe that that is something that's being discussed by the schools right now. They are-- they will be in charge of sending letters out to parents to get consents signed and sent back in. And that's a really good question and something that I-- I can't answer directly at this point, but it's certainly on the list of things that we need to do. But I believe that the responsibility for that will fall mainly to the schools and the daycares to obtain those consents.

SECRETARY BREMBY: Okay. Colonel Maple. What are the plans for forced isolation or quarantine?

COLONEL MAPLE: Those are something that will be, you know, determined at the time. And, you know, there are statutes and different things in place. And hopefully we never get to that point, but they are being discussed and considered and plans for that are being developed. Hopefully, you know, by educating folks and getting enough information out there, that-- that it won't be necessary to enact measures of that magnitude.

SECRETARY BREMBY: Okay. Alexa.

Should it be optional for schools to hold vaccination clinics or should schools' participation be mandatory? We are meeting a lot of resistance from our superintendents.

COMMISSIONER POSNEY: We are receiving? Okay. Let me go back to mandating versus making it voluntary. I'm always a-- a good believer in not mandating something that's-- that's highly effective. Usually what we can do is, peer pressure alone will encourage the-- the schools to do that. The other reason not to make it mandatory is that there are always reasons why some cannot do that. Whether-- you know, in this day and age, there's so many school nurses that were cut, so there may be some issues in terms of why some school districts cannot.

However, what we will do is work with them to encourage them to do it as much as we possibly can. And with those who can't and-- and I know that there are good reasons, we'll try to find other ways to work with the communities.

SECRETARY BREMBY: Okay. Claudia, you discussed what your agency is doing. Do

you feel other counties' efforts are similar?

MS. BLACKBURN: Well, I would like to clarify. I did visit with a colleague during the break. And just to make sure everybody understands, I was speaking about Sedgwick County and what our plans are. And I can't speak for the plans of all the other health departments in the State of Kansas, all the other local health departments. But I'm pretty sure that most health departments are informing the public, getting the-- the messages out about how to prevent the transmission of disease, working on a vaccine campaign of some kind and working with our partners. And-- and that is just something that we do. I mean, some local health departments have more resources than others. And for-- we all have to work with our partners. Some of us may rely more on our partners for certain things than others. So in general, we're moving in the same direction, but the specifics may be different.

SECRETARY BREMBY: Okay. Thank you. Jason, I'm going to combine two questions. First is, the information about surveillance

cultures, how many per week and from what patient types? And then can you talk about confirmed cases in counties if now suspect cases are not being tested. So if you could talk about the change in the system of surveillance.

DOCTOR EBERHART-PHILLIPS: Right. It-- this is-- this-- this is requiring a different mindset in terms of how we're-- we're able to monitor the spread of the disease and-- and at the same time try to serve the health care community with the information they need to make clinical judgments at the point of patient care.

To-- up to now, the caseload has been within the-- the limits of what the very scarce and expensive resources are to do this specialized subtype testing in-- in Kansas. We-- we get these reagents, they're only available through the CDC and we're only allowed so-- so much of it. They require very expensive machinery to do this PCR testing and then highly-specialized staff to be trained who can do it. We-- we're really hoping that none of them gets sick through this.

And-- and our capacity, if we just worked them flat out and-- and-- and pushed them to the limit, is to test about 100 people a day, and we can go through the weekends. But at some point they're going to need a break. So if we're talking about tens of thousands of cases of potential illness, there's simply no way that we can satisfy every clinician's curiosity about whether or not this particular flu-like illness that they're seeing is definitively this organism.

So what we can do is try to measure the overall flu activity in terms of these clinical systems and get these sentinel providers in, we hope, virtually every county of the state to notify us of the proportion of cases that they're seeing, among all the other people they're seeing about their-- their diabetes and about their-- their heart disease and everything else, of all the cases they see how many are coming in for this. It may be 5 percent, it may be 10 percent, it may be 30 percent. And we-- we'll try to-- to monitor that week-to-week and then we'll ask them to collect just two, you know, randomly-selected -

hopefully they're from different families - specimens that they will send in. And-- and that will just about absorb our capacity if we also try to do all hospitalized patients.

For disease that's severe enough to put someone in the hospital, it's our goal to continue to provide that testing service to the clinicians who-- who need it. So in combination, looking at those hospitalized cases and then looking at those routinely-collected specimens, we hope we can get a picture of just what share of the flu-like illness is due to this organism. But in terms of how-- how that will help you with managing an individual patient, that's just not something that in the face of a pandemic we can continue to do.

SECRETARY BREMBY: Okay.

DOCTOR EBERHART-PHILLIPS: Is that both of your questions or just one of them?

SECRETARY BREMBY: I think that got both of them.

DOCTOR EBERHART-PHILLIPS: Okay.

SECRETARY BREMBY: General Bunting, what's the status of the availability of the

web-based COOP planning program for county use? Any chance we can start using it now?

GENERAL BUNTING: Okay. Okay. It's being tested in two counties. Our planner was out there to answer that one, so...

SECRETARY BREMBY: Okay.

GENERAL BUNTING: So if you're one of those two counties, the answer would be yes. But to the other 103, it's-- we want to roll out a product that actually works, so...

SECRETARY BREMBY: It will be coming.

GENERAL BUNTING: Right.

SECRETARY BREMBY: Torrie, any possibility that your business will require employees to get H1N1 flu vaccinations?

MS. BEHNKE-SPIEGELHALTER: We actually discussed that yesterday. At this time no, that's an area that we are-- are not commenting on. And again, we're following the guidelines from the World Health Organization and the CDC.

SECRETARY BREMBY: Okay. Doctor Cooley, would you be willing to call or talk to MDs who are not following CDC guidelines?

DOCTOR COOLEY: Do you guys want me

to get beat up or what? You know, I-- I think you're right, there is-- there is a problem. And-- and this gets down to, especially with the use of things like Tamiflu, that when you have providers who just, you know, will go ahead and write prescriptions for this without using the guidelines, I think that this puts us all in a-- in a bad bind. And the worse thing that can happen is for me as a provider when, you know, I have a mom bringing the kid in and, you know, the kid has a mild disease maybe and doesn't really fit the criteria and she says: But my doctor gave me and my husband Tamiflu. Boy, what am I going to do? You know, I'm the Grinch.

So you're right. I think that's it. Part of it, I think a lot-- or not part of it, but a lot of it probably has to do with the fact that I-- I'm embarrassed to say that I'm not sure providers are keeping up with this. I'm not sure that they are following CDC guidelines by-- when I say following it, I mean they're not aware of what these guidelines are. And so I think to a certain degree, you know, providers need to step up a little bit to the

plate.

So one-- one other thing, too, that goes back to the-- to the question that went to-- to Doctor Eberhart-Phillips is that, you know, truly getting tests done on these patients when they come in-- in a-- during a-- a pandemic when we know that there is a large amount of this in the community, that's not going to benefit me as a provider, quite frankly.

I mean, I'm going to treat these patients. Quite frankly, all it would do is slow me down a little bit, trying to get these specimens and having my staff then send them off, et cetera. So, you know, that really-- once we know that there's a large amount of the-- the illness in the community, we truly don't need to be checking everybody.

SECRETARY BREMBY: Okay. How about Alexa again. I think I've got two for you, Alexa. One is: Please discuss the possibility of the government mandating H1N1 flu vaccines for public school students. And then I'll follow with the second.

COMMISSIONER POSNEY: I-- I do not think that-- I don't think they'll do that.

And it's just because there are so many individual choices that are out there in terms of, you know, parental control and all of that that I-- I cannot imagine that they would make that decision. Would it be a good idea to have as many vaccinated as possible? Absolutely. But I still believe we probably need to leave it to parental choice.

SECRETARY BREMBY: And the second would be: When you reference school-based clinics, are you referring to clinics during school hours or during non-school hours?

COMMISSIONER POSNEY: For me, again, I would leave it up to the-- the local control to make that decision, but I don't see any reason why it could not be done during school hours. I know they have run clinics in the past and they do do it during the-- the school hours. But in some cases, maybe they'll need to do it-- extend the-- the time frame.

SECRETARY BREMBY: Okay. All right. Let's see. Jason, you're really lined up here, so get ready. Has the state decided how it will allocate vaccine by population base, by county and who's paying for the vaccine?

DOCTOR EBERHART-PHILLIPS: Let me answer-- answer the-- am I on? Let me answer the-- the first-- the last part first. We're all paying for the vaccine, it's being purchased on our behalf by the federal government. We're privileged people in this world to be able to access this vaccine. Most of the other 6 billion people on the planet won't. And we and a few other countries in western Europe, Australia, and Japan have pretty much hoarded the entire world's capacity at-- at making this vaccine and-- and it's being purchased for all of us for us to use and for all of us in this room to help promote to the people.

In terms of how we're going to distribute the vaccine, we-- we have a-- a very hard-working immunization program at KDHE who is going to be working in very close concert with all 100 local health departments to identify providers in every county who can do the immunization. We're looking at between 8 and 900 providers. And then within counties, there can even be more than that with the vaccine supply being routed through local

health departments.

We'll have to ration the supply that we have when the initial shipments come to the state. But we're going to do that in a way that's fair and equitable based on the population needs and based on the previous use of flu vaccine and vaccines for children that have been required in the past and whose records we can access.

SECRETARY BREMBY: Okay. One more and then we'll head back over to Alexa and Claudia, unless I can get one for General Bunting. Vaccine. If a person had H1N1, are they still being encouraged to take the vaccine when available? So that goes to the issue of some immunity.

DOCTOR EBERHART-PHILLIPS: Right. It-- it's certainly not going to harm the person to get immunized even if they've already been infected. We-- we anticipate that--

SECRETARY BREMBY: Bless you.

DOCTOR EBERHART-PHILLIPS: -- you know, there will have already been a few thousand people in-- in Kansas who have been infected. The problem is that no more than

about 350 of them would have ever received confirmation of that through our laboratory. So even if you think you've been infected previously and you are, therefore, immune at least for the coming flu season, it still would be a good idea and it won't harm you to get the vaccine.

SECRETARY BREMBY: Okay. Now, General Bunting and then I'll go back over. Can someone address the vaccination plan for personnel and family members of the Kansas National Guard.

GENERAL BUNTING: Well, we're-- we're just going to fall in wherever we fit in society. So that's what we are, we're part of society so we won't be any different than that.

SECRETARY BREMBY: Okay.

GENERAL BUNTING: I mean, we have members of the National Guard that are in the health care business and so they would come up in there. And the rest of us would be just like everyone else here.

SECRETARY BREMBY: Okay. Question for Claudia and Alexa. Are we educating parents on what medications can be used to help

relieve symptoms rather than going to ER or doctor's offices unless the symptoms escalate? So I guess it's getting to educating parents on what to look for.

COMMISSIONER POSNEY: Part of what-- what we have done and what's going out on the website and what will be sent out to the schools are information that the-- the-- the principles and superintendents can send out to their parents just in terms of, you know, the good practices that I shared with you, as well as we will send out periodic things to look for in terms of what the symptoms are. And we will keep doing that. And we'll send it in hard copy and we'll put it on the computer any way that they can access the information. It's one of the reasons we're do the magnet, something that catches their eye.

SECRETARY BREMBY: Okay.

MS. BLACKBURN: In terms of including information in our vaccination campaign about what kinds of over-the-counter medications parents can use for their children, that is not part of our campaign at this time. Something certainly to look at. We generally refer

people to their private providers to get that kind of advice, because there are many different situations out there and some children can't take certain drugs. And so we would generally refer people to their private providers. And I would imagine that's what the schools do as well. But it certainly is something to think about and visit with our-- our local providers about to see if they have any feelings regarding that issue, so...

SECRETARY BREMBY: Thank you. Doctor Phillips and Doctor Cooley. Compare and contrast the expected numbers of infected and numbers hospitalized and number of deaths of normal season flu to H1N1 for the coming 2009, 2010. It comes from Hays, out in Hays County.

DOCTOR EBERHART-PHILLIPS: Well, the-- the-- the total numbers are probably on the order of roughly double in terms of the incidence of disease, the incidence of severe disease requiring hospitalization, and the likelihood of deaths. But that's, still, with a lot of uncertainty around it. We cannot absolutely predict what-- what it's going to look like. But if it's falling into the

category of the Asian flu of 1957, '58, then that's the kind of picture that we would anticipate.

SECRETARY BREMBY: Okay. Claudia, if I'm a disabled person in a local community, are there special provisions to ensure care if I contract H1N1?

MS. BLACKBURN: If we got to the point where we had so many sick people that the health care system was overwhelmed, then we would look at the possibility of setting up clinics that would be sort of minimal care for people, if they didn't have anybody to take care of them. Or shelters. It would be a shelter-like situation.

Other than that, I-- I would refer people to their-- their private physician. If they don't have a physician, then to one of our safety net clinics. In a normal situation, unless we get to an overwhelmed health care system, I don't know that there's a-- a special provision for people that have disabilities, other than the-- the system that we have, which we certainly hope is-- is open and hospitable to people with disabilities.

SECRETARY BREMBY: Okay. A question for the doctors again. This is very similar to the other one about the person contracting H1N1 virus and getting to the immunity, but this is specifically a school-aged child. If they contract H1N1 flu prior to receiving the vaccine, should they be advised to have the vaccine when it becomes available or would they have immunity?

DOCTOR EBERHART-PHILLIPS: They-- they would likely have immunity if-- if that's really what they had. But they have nothing to lose by taking the vaccine to ensure that they're protected just in case they had something else.

SECRETARY BREMBY: Okay. You're good with that, Doctor Cooley?

DOCTOR COOLEY: Yeah.

SECRETARY BREMBY: Okay.

DOCTOR COOLEY: And-- and again, you know, a lot of people are-- assume that they've got-- had H1N1 because they had flu-like symptoms. And they may not have. The number of-- of kids that we know for sure had it is probably not a very large number. So does it

hurt to get the vaccine? No, not at all. And probably would advise it.

SECRETARY BREMBY: Okay. This question is for Jason and Torrie. Torrie, if you could handle this from an industry perspective. But where can we get reliable information on how the rest of the world has handled H1N1 issues, and what were those major issues from an industry perspective where supply is disrupted, communication is disrupted. And then, Jason, hospitalization rates in those countries.

MS. BEHNKE-SPIEGELHALTHER: Was the question if we had experienced that in other--

SECRETARY BREMBY: As Homeland Security is observing what's occurring in the world, are-- what are some of the-- the disruptions that you're seeing in industry, for example?

MS. BEHNKE-SPIEGELHALTER: Particularly the supply chain, getting-- getting the piece parts that keep the-- that keep the bus in motion in understanding the-- the number of spares that you have and what, again, those interdependencies and the-- but

it's-- it's basically supply chain. It's just the widgets, it's the little parts that make the rest of that world go round. But I don't have specific examples.

SECRETARY BREMBY: So as you're doing your COOP planning, it would be helpful to go up the supply chain to make sure that your vendors or your partners are also planning for impacts?

MS. BEHNKE-SPIEGELHALTER: Absolutely. And then again, tying that back to those mission-critical essential functions, not trying to net that out for all of your organizational practices, but, again, identifying those key components and looking at the suppliers that provide those particular capabilities.

SECRETARY BREMBY: Okay. Thank you. And Jason, is there a place where someone can go to see what's happening worldwide or globally and hospitalizations and the like?

DOCTOR EBERHART-PHILLIPS: Well, KDHE staff has been monitoring for me just the-- the activity and-- and what-- what they're seeing in the national websites from the southern

hemisphere, and that's where I've been getting my information. Just aside from personal contact, having once practiced myself in New Zealand, I-- I know the-- the people there at, say, Cristchurch Hospital when they're saying that, you know, they-- they've never seen anything like this in their pediatric wards, that they-- they are at critically-low levels at the peak of the-- of the outbreak in terms of certain critical supplies. And the ability to perform any non-essential care was-- was-- was greatly reduced. And that that kind of spotty picture of severe acute localized shortage was typical around that part of the world last month.

SECRETARY BREMBY: Okay. Alexa, could you discuss liability issues for schools if they provide vaccination opportunities due to adverse reactions?

COMMISSIONER POSNEY: It would-- it's something that the-- the schools and districts have already looked into, because they have run clinics or immunization clinics in the past. And, you know, the liability issue would be exactly the same as it was, you know, in terms

of any school nurse. And, you know, I-- I'm not exactly sure of all the laws, but I know that they have checked out all the liability issues.

SECRETARY BREMBY: Okay. Thank you. One last question for Jason. And that is: What does H1N1 mean? How is that different from H2N2 or H5N1 or others, so...

DOCTOR EBERHART-PHILLIPS: We call it H1N1. The-- the kids at my kids' school call it "hiney" flu because they think those are Is and they think that's really funny. But the H and the N refer to the two proteins on the surface of the virus particle. The hemagglutinin, the H protein, and the neuraminidase, the N protein. And virologists who-- who really get into these things have-- have a way of recognizing about nine different classes of H proteins and some odd number of-- of N proteins. And when they see an N-- an H and an N1-- an H1 and an N1 together, that's-- that's what they name the virus. It's not the same virus as the H1N1 virus from 1918, it just has those two marker proteins that are in that same general family.

SECRETARY BREMBY: Okay. The last question is somewhat peculiar in that the answer probably lies out there. There were four questions received about an incident that's occurring on the KU campus. The last question of which is most clear said: A number of cases have been identified at KU, and what is the status of the situation?

I think we have representatives from the local health department, Dan Partridge, as well as representatives from KU. So if either or all would like to come up and take the Donahue mike to fill us in on the latest information, we would be-- we would appreciate it. Making his way up is Dan Partridge, who's the Director of the Douglas County Health Department, Lawrence/Douglas County Health Department. And you have another partner. Come on up.

MR. PARTRIDGE: I'm looking for Carol Seager (INAUDIBLE) .

SECRETARY BREMBY: Okay. And Carol Seager. Is Carol still here? Okay. I think that means that she turned it over to you. And you're in good hands with Dan.

MR. PATRIDGE: I'll have to thank her

later. The situation at-- at KU is-- is really, I think, one that's common in a lot of places. It's miscommunication. And what we label-- what we think we've labeled properly, people misperceive.

What the student clinic is doing is: If you have flu-like symptoms, they're saying isolate yourself, go back to your dorm room, we'll move your-- your healthy roommate to another room. If you're well enough to go home, go home. They're trying to be very proactive in-- in trying to limit the spread of disease at the university, following those CDC guidelines.

And then those children go home and, you know, the story kind of changes with each telling of it. And so it's not that we have 50-some cases, that number changes every time I hear it, of-- of H1N1, it's just that 50-some people showed up, students showed up with flu-like symptoms. And so those are two very different things.

SECRETARY BREMBY: Okay. Thank you, Dan. The-- the information or the interest has spread nationally as there was several

inquiries from CNN this morning. So let's make sure we get the communication correct. So thank you, Dan.

MR. PARTRIDGE: Yes.

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GENERAL BUNTING: Okay. I know Doc has much more extensive notes, so I'll just-- a couple comments. I did listen intently when the Governor had three points, and I think they were spot-on. This has the potential to be a very serious health problem. Agreed. We should prepare for the worst. I-- I lead a department that that's pretty much all we do. We're the most paranoid people in the State of Kansas. We always prepare for the worst, and the military is pretty darn good at that, too, so, okay, duly noted.

And then finally he said it's-- we will need unprecedented cooperation to get through. And that's why I started off with the introductions I had, and I turn in this room and say that's what it's going to take. It's going to take just thinking it through and being prepared. And the solutions are going to come to people with a-- a large amount of

common sense.

So my message, my summary, would be: In your own business, where you're at, think of those places where you have single points or people that do so much for you that simply the things won't run on time if we don't have them. The-- the one superintendent talked about they have one person that does payroll. So I'm just urging you, you need to go back and think about that. Who do you have like that at work that everything revolves around.

And then here's a second one that's even harder. Think about when you go home at night and who you have in your home or in your family that is that person that everything runs around and all of a sudden things don't go too well if they're not available. Looking around this room, I'm going to guess that in many cases it's you. Okay? And I mean that with high praise.

But at the end of the day, you still need to have a plan so that it isn't: Well, mom has always done that, we don't have a plan around that. Most of us didn't, but you need to have that. So it's really going to come down-- we

could talk for a long time about the various systems in place and the plans that are on that. We have all that and we'll continue to refine them. But it's still going to come down to having a continuity of operations plan for yourself and for where you work. And we do that and we work together and everybody understands that we'll get to those essential services. That's the key. It's-- it's-- it's been that way for a long time and it's still that way today.

DOCTOR EBERHART-PHILLIPS: I wanted just to conclude by thanking you for all coming, for all of you in this room and in the televideo sites around the state for taking the time to get acquainted with this issue and to think deeply with us about the-- the ramifications of this.

In particular, I wanted to make sure I took this opportunity to publicly thank all of you who work in local public health departments and at hospitals and clinics around the state. We would not be able to do what we're envisioning needs to be done without your full partnership with us at KDHE. And it's-- it's

so crucial that we have that. So thank you very much.

None of us wishes that this summit was necessary. A flu pandemic is about the last thing that we need right now in our complicated lives, particularly in the middle of a severe recession. But like it or not, it's here and it's-- but what we've heard today convinces me that Kansas is on the right track to respond to the pandemic effectively.

We heard the Secretary of Health & Human Services tell us that a escalation of cases this fall is likely. But that a partnership is in effect with, what she said, all hands on deck. We heard the Governor of Kansas say that this will require an unprecedented level of cooperation. That proper planning can and will minimize the impact of this disease on Kansas. And that while we are hoping for the best, we can be prepared for something much worse.

We've heard a distinguished local public health official tell us that they are ready to do the work that's involved; the public information, monitoring the community for disease, implementing a vaccination plan and

acquiring the necessary resources. We heard the Adjutant General tell us that Kansas has been planning for this day for many years, and that essential state functions have been identified and that employees in critical positions are being cross-trained.

We've heard the state's leading law enforcement officer say that his troops are adjusting to new roles, to partnership roles, ready to aid the state's response to this threat. We've heard the Commissioner of Education say in no uncertain terms that schools will be the most critical piece of the state's response.

We've heard an experienced school administrator tell us that the time has come for schools to renew their crisis management plans, to update their contact information, to renew their contact with the local health departments in their areas, and to get ready for school-located vaccination programs.

We've heard a prominent Kansas pediatrician tell us what it will be like from the front lines and how offices like his could be swamped. We've heard a leader in business

show us how they as an at-large employer are ready with contingency plans and, as a communications provider, how they will be able to mitigate against the impacts of this on the communications network.

Our joint message from this summit is clear. As Kansans from across this state working in every sector, we are taking this new threat very seriously. And together, we are making preparations to lessen the negative impacts of this disease on our people and our economy. And we are asking you today to join us in this effort.

We've covered a lot of ground today. For those of you who haven't been dwelling on this subject like we have in public health for the last four months, there is a risk of information overload. The prospect of large numbers of people becoming ill, some of them very seriously, can be daunting when you consider that possibility for the first time. And the work that lies ahead of us in public health in staging the largest immunization effort in the history of this country can be, frankly, overwhelming at times.

We are in for a long journey with this organism in the coming months. And my advice is that we take it one step at a time. Let's see if we can each take one thing away from today's conference and bring it home to the places where we live and work. Maybe that thing would be looking into the sick leave policies in the places where we work to see if they could be made more flexible to accommodate the absenteeism we expect.

Maybe we could make that one thing to consider ways that we could work with our local health departments to make this new vaccine available in schools or in workplaces or how we could help them to recruit the volunteers that they're going to need for this massive undertaking.

Maybe that one thing could be examining ways that we can slow down the spread of this infection in the places that we work, attend school, worship, and play, with more attention paid to personal hygiene and responsible social distancing measures.

Maybe one thing we could all do is to put special effort into making sure that all the

people in our lives, all the people around us know for sure what this flu is, how it spreads, and how they can use the power in their own hands to prevent it for themselves and for their families.

So thank you for-- all for coming today and learning with us.

C E R T I F I C A T E

STATE OF KANSAS)
) ss:
COUNTY OF SHAWNEE)

I, Kelli Stewart, a Certified Shorthand Reporter in and for the State of Kansas, duly commissioned as such by the Supreme Court of the State of Kansas, do hereby certify that I was present at and reported in shorthand the foregoing proceedings had at the aforementioned time and place; further that the foregoing 142 pages is a true and correct transcript of my notes requested transcribed.

IN WITNESS WHEREOF, I have hereunto affixed my Official Seal this_____ day of _____ , 2009.

/s/ Kelli Stewart

KELLI STEWART

Certified Shorthand Reporter